Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 230 Month JULIUS 8 DONALD 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street end number) 4c. County of Death LEVINDALE NURSING HOME BALTIMORE N/A 6. Sex 1 M 2 ☐ F ff Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Deys Hours 88 216-10-0871 AUG.15,1910 **Usuel Residence of Decedent** 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1500 BEDFORD AVENUE #306 21208 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? NAV 12 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, NAVY Bleck, White, etc. 1 ☐ Never Merried 2 Merried 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced WWII Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 CHAUFFEUR TRANSPORTATION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) MANUS DONALD SOPHIE CHRISMAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ANNA DONALD / WIFE 1500 BEDFORD AVE. #306 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion _5 ☐ Other (Specify) 5 Other (Specify) HAR SINAI BENEVOLENT SOC. 4/19/99 ROSEDALE, MD g Funeral Service Circ 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Perf1. Enter the disease, or complicet on their caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one years an each line. Approximete Intervet Between Onset and Death Immediate Cause (Final diseese or condition resulting in deeth) e to (or es a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest nentra Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart ongestive 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No

Box or Attanding Physician: Division of this death. after death

Physician

/Medical

Examiner

Director

Funeral

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Item 27 ls other tra

Physician /Medical

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21215-0020

Baltimore, Maryland

Physician/Medical þ Completed Be Medical Certification: To 1 Neturel

25. Was case referred to medicat examiner? examiner/ 1 ☐ Yes 20 No 27. Menner of Deeth 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(Check only

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pieca, and due to the cause(s) end menner stated.

29b. Signeture end title of cartifier

29c. License number

29d. Dete signed (Month, Dey, Year)

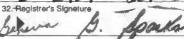
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Balto, PH 212, 5MD 31. Dete filed (Month, Dey, Year)

State Registrar

DHMH 16 Rev 6/95

within 24 hours a To the Funeral D Hospital

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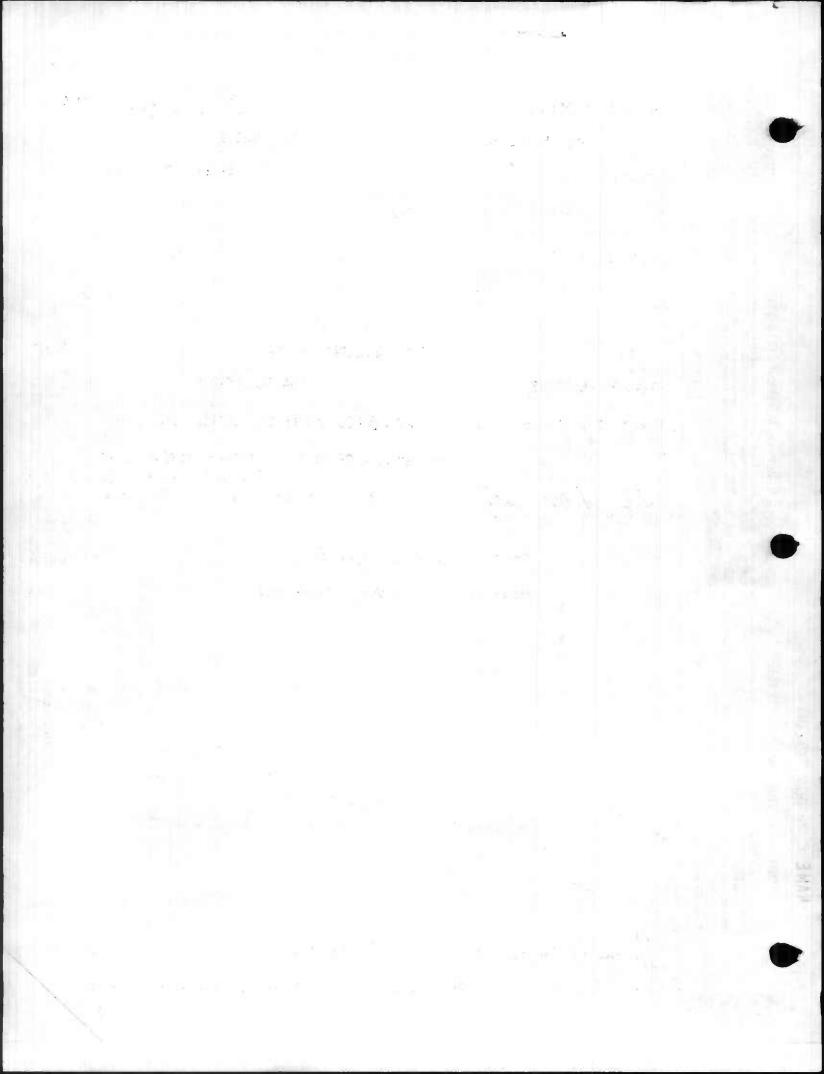
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** 0006 APRIL, 16 HELEN K. ELDRIDGE 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner BALTIMORE ST. AGNES HOSPITAL If Undar 1 Year 8. Date of Birth 11-02-1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** 1□M 2X F Months Days Hours Min. Yrs. 85 MD. **Director** 213-22-2012 Usual Residence of Decedent the Meryland 10b. County r 28a-f show 10a. Steta 10c. City, Town or Location 10d. Inside City Limits ELKRIDGE HOWARD 1 Yas 2 No MD. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nest of Health and Mental Hygiene.

Artif frem 27 is marked other than "natural; or items 23a or without protection to the marked other than "natural" or other traumatic event, fire Mental at Eastmen mail to a large. USA. 6448 JULIE ANN DR 21076 Funeral 12. Was Dacadant Ever in U.S. Armed Forces? 1 ☐ Yas 2 1 No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. 1 Nevar Marriad 2 Married 1 Yes 2XXVo Baltimore, Maryland 21215-0020 Specify: Specify: BLACK g 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) FORT GEORGE G. MEADE D.C. CHILDREN CENTER 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) NEDA BLACKSTONE HORACE BLACKSTONE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 6448 JULIE ANN DRIVE ELKRIDGE MD. 21076 MARGUERITE ELDRIDGE 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition XBurial 2 Cremation 3 Removal from State Department of important: If any Injury or poice. 4-20-99 ELKRIDGE, MD. MEADOWRIDGE CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1300 EUTAW PLACE BALTIMORE MD. 21217 Esla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or healt failure. List only one cause of each line. Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Acute myocardial interction 50 minutes Examiner Examiner o. Atteroscleratic cordovascular disease loyears physician and s the buriel-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of): attending ph for use es t signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes SHITNO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 Yes 2 No investigation 2 Accident after deat Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral Completely filled 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Certifier edical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) 022648 orman ms TPRIL 16, 1999 secome & JESOME 1. Snyder m.D. 900 SOUTH CATON ALTHOUGH BALTIMERE, MARYLAND 21228
31. Dete filed (Month, Dapper 21 19962. Registrar's Signature

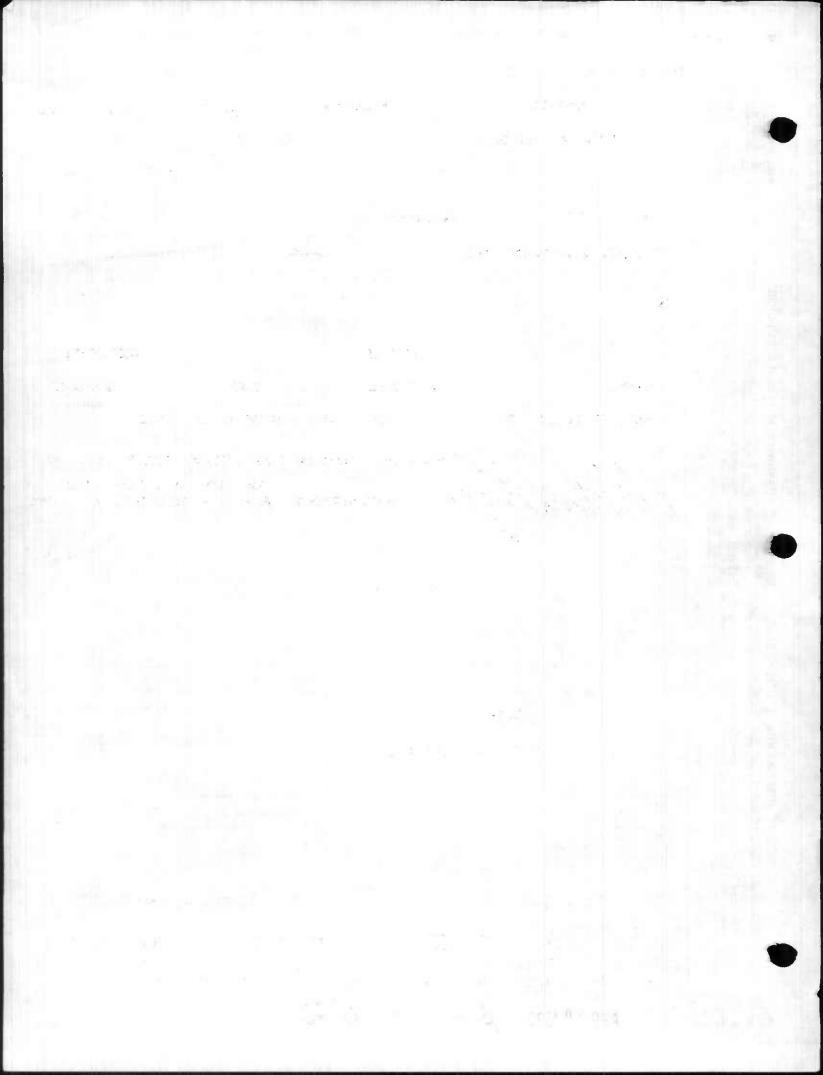
AME ELDRIDGE, HELEN

State Registrar



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| | Item: 10f per F.H G-77 | State of Ma 70 4/21/99 re | | epartmer Certificat | | | nd Me | | iene 9 9 | 1 | 3003 | |
|--|--|---|----------------------------|---|-----------------------------|--|-------------------------|---|-----------------------|-----------------------------|--|--|
| Dharistan | 1. Decedant's Nema (First, Middle, La | st) | | | | | | 2. Dete of Deet Month | h Day | Year | 3. Time of Death | |
| Physician /Medical | ANNET | re K. | | ELLE | - | | | Aprel | 4 | 999 | 0600 | |
| Examiner | 4a Facility Neme (If not institution, giv LEVINDALE NUR | | | | | 4b. City, Town, or Location C BALTIMORE | | | N/i | | A | |
| Funeral Director | 212-14-3733 | ex 7. Aga | (In yrs. last birthe | Months | Deys | If Under 2 Hours | Min. | B. Data of Birth (Month, Dey, JULY 3, | ^{Year)} 1914 | 9. Birthp Cour | elece (Stete or Foreign etry) MD | |
| 72 hours efter death with the Maryland natural; or items 23a or 28a4 ahow deal Examiner must be notified all eted by Funeral Director | Usuei Residence of Decedent 10e. State 10b. County MD N/A | | 10c. City, Town of BALTIMO | | | | | | | 1 | 0d. Inside City Limits 1 Yes 2 No | |
| with the Mai 3a or 28a-f at it be notified I Director | 10e. Street end Number 6300 RED CEDAR | PLACE #104 | 4 | 10f. Zi | Code -21 | 21209 208 | | 10 | Og. Citizen of V | Vhet Cour | | |
| The roots ener death with the maryer "natural", or items 23a or 28s-4 should call Examiner must be notified at letted by Funeral Director. | 11. Marital Stetus 1 □ Never Married 2 □ Married ③☑ Widowed 4 □ Divorced | 12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yaer or Datas: | ver in U,S. | 13. Was Dece If Yas, spe 1 Yes | | ispenic Origi n, Mexicen, Specify: | in? (Spec Puerto R | ify Yes or No- ican, etc.) | | k, White, | ean Indian, etc. | |
| | 15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12) | | +) | ecedent's Usu Give kind of wi ife. DO NOT u | ork done o | during most | of workin | | | usiness/Industry EDUCATION | | |
| if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ma | 17. Fether's Neme (First, Middle, Last BENJAMIN |) | | ENSTEI | I SR | | r's Name | (First, Middle, A | | e) | STDORF | |
| If and I | 19e. Intorment's Neme/Retetionship (BERNARD ELLENSO | | | Mailing Addres 7 OAK A | | | | Route Number | City or Town, 07670 | State, Zip | Code) | |
| Department of Health Important: If Item 27 any Injury or other tr | 20e. Method of Disposition 1 Burial 2 Crametion 3 4 Donation 5 Other (Special | | 140 | cremetory or | other plea | | ADV | Dete 3 | 20c. Location - | | OWN, MD | |
| sician end sunial-transit sician end sunial-transit sal Examiner | Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any leading to immediate | b | Due to (or es a co | EVD | | | | | | | minutes | |
| g physicia es the bur ledical | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest | c | Due to (or es a co | nsequence of) | : | | | | | | | |
| igned by the attending be deteched for use e by Physician/M | Pert It. Other significant conditions of | ontributing to death bu | t not resulting in t | he underlying | ceuse giv | en in Pert t. | | | | | o the cause of death? bably 4-4 Unknown | |
| 2 should | | Cardio | myopath | 7 | | | | 24e. Wes e perform | ned? | av cc of | Vere autopsy findings reileble prior to implation of ceuse deeth? | |
| s certificate he director, page | 25. Wes cese referred to medical exeminer? | | | | | 26. Place | of Deeth | (Check only on | e) 25 No | 11 | ☐ Yes 2☐ No | |
| | 1 Yes 2 No 27. Menner of Deeth | Hospital: 1 □ Inpatie 28a. Dete of Injur (Month, Dey | y 28b. Tir | | OA Oth 28c. Injur Wor | 4∐ Nur | | Home 5 ☐ Residence 6 MOther (Specify) | | | | |
| within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: 7 | 1 Natural 5 Pending 2 Accident investigetio 3 Suicide 6 Could not be determined | k? Yes 2□N | | 8f. Location (St City or Town | | per or Run | al Route Number, | | | | | |
| within 2 hours after within 2 hours after Completely filled in Medical Cert | 29a. Certifier to Certifying Phase (Check only one) 2 Madical Example (Check only one) | yatctan: To the best o niner: On the basis of end menner sta | examinetion and/ | deeth occurred or investigation | l et the tin | ne, dete end pinion, deati | d piece, a h occurre | nd due to the co | ete end plece, | enner es s and due t | stated. o the ceuse(s) | |
| within To the compl | 29b. Signature end title of certifier | | 0 | 29 | | e number 7 375 | 73 | 2 | 9d. Date signe | | Dey, Year) 7, 1999 | |
| | 30. Name and address of person who | completed cause of de | | 1 | ve | Bal | timo | MÞ | 21208 | 3 | | |
| State Registrar | 31. Dete filed (Month, Dey, Yeer) ADD 2. 0 10 | | r's Signature | 4 1 | 200 | > : | | | | | | |



| 99-2277-53 | 10 | Ple | | or Print in | | | | | | | | | | |
|---|--|--|---|---|----------------------------|-----------------------|----------------|---|---------------------------------|--------------------------------|--|--|--|--|
| LEROY FUTRILL | | | Sta | te of Maryl | | ertificat | | | | nental Hy | ygiene Reg. No. | 00 1 | 3006 | |
| Physician | 1 - 0/10 | eme (First, Mic | | | | | | | | 2. Data of D Month APRIL | Dey | y Year | 3. Time of Death 7:49P.M. | |
| /Medical Examiner | 48 Facility Neme | e (If not institut | ion, give street a | nd number) | | | | 4b. City, To | | ocation of Dea | | County of Death | | |
| Funeral Director | 5. Social Security 241-22- | 7152 | 6. Sex 1% M 2E | | vrs. last birthday Yrs. | Months | 1 Year Days | If Under | | 8. Date of B | 8. Date of Birth (Month, Day, Year) 5-3-1918 | | 9. Birthplace (State or Foreig Country) NC. | |
| Maryland of show fied at | 10a. Stete | 10b. Coun | ity | | City, Town or L | | | | | | | | 10d. Inside City Limit | |
| In with the Mary 23e or 28e-f sh at be notified. | | | | | DALTIMO | 10f. Zip | | | | | | Citizen of What Country? | | |
| 0020 ours after death view, or flamm 234 Examiner mant | 3 ☐ Widowed | | 12. Wes | 1-1-45 to 26-47 | Wes Dece | dent of I cify Cub | an, Mexica | n, Puerto | pecify Yes or N Rican, etc.) | lo- | 14. Race - Amer Bleck, White Specific LAC | , etc. | | |
| Maryland 21215-0020 at about be fled within 72 hours at th and Mental Hyghere. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F | (Sp Elementery/Se | 15. Decedo pecify only high econdery (0-12 | eted) ege (1-4or 5+) | life DO NOT use n | | | | d of work done during most of working NOT use retired) | | | | 16b. Kind of Business/Industry RAILROAD | | |
| Vland Suld De filed Vlental Hyper riced other ritic event, | 17. Fether's Nem | ne <i>(First, Middl</i> NKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN | | | | | | | | | | |
| Baltimore, Mary semil. Pages 1 and 2 sho begarment of Health and reportant if them 27 is ma my injury or other traums book. | 20e. Method of D | N B. FU | 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3727 BELLE AVE. BALTIMORE MARYLAND 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) GARRISON FOREST V.A. CEM. 4-27-99 GARRISON FOREST, | | | | | | | Town, Stete | | | | |
| Balti permit. Departm imports any into | 21. Signeture of | Funerel Service | e Licensee | tes | 2 | 2. Neme ar | nd Addre | ess of Fecili | VEST | EP BRO | THERS | FUNERA RYLAND | L HOME P.A | |
| Physician /Medical Examiner | 23a. Pert1. Ente shock, or h Immediate Caus disease or condi resulting in deat | e (Final | st only one causi | that caused the de on each line. | | | | | | | errest, | 1 | Approximate Intervel Between Onset end Death | |

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the bunta-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Medical Certification: To Be Completed by

Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were sutopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? INSPECTION

1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospitel: XXYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28e. Dete of Injury (Month, Day Year) 28b. Time of injury 27. Menner of Death 28c. injury at Work? Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

O.C.M.E.

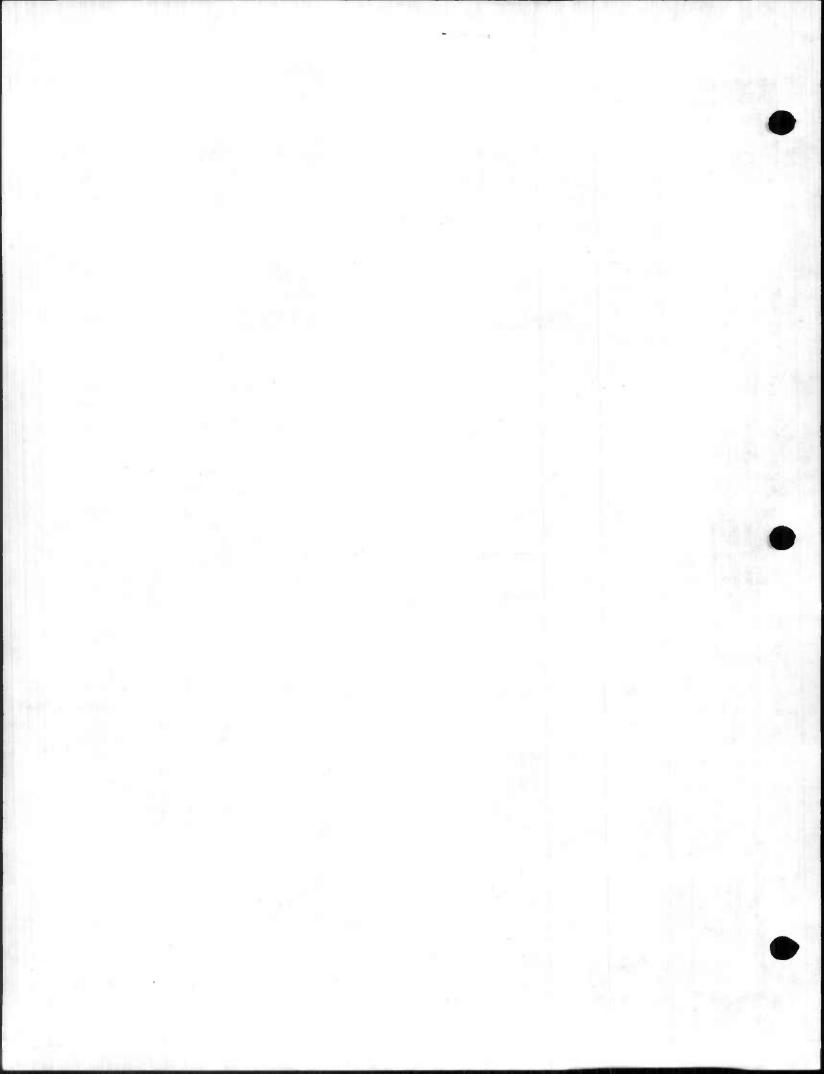
29d. Date signed (Month, Day, Year)

APRIL 20,1999

eddress of person who completed cause of deeth (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Manth Day Year)

29b. Signature end title of certifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

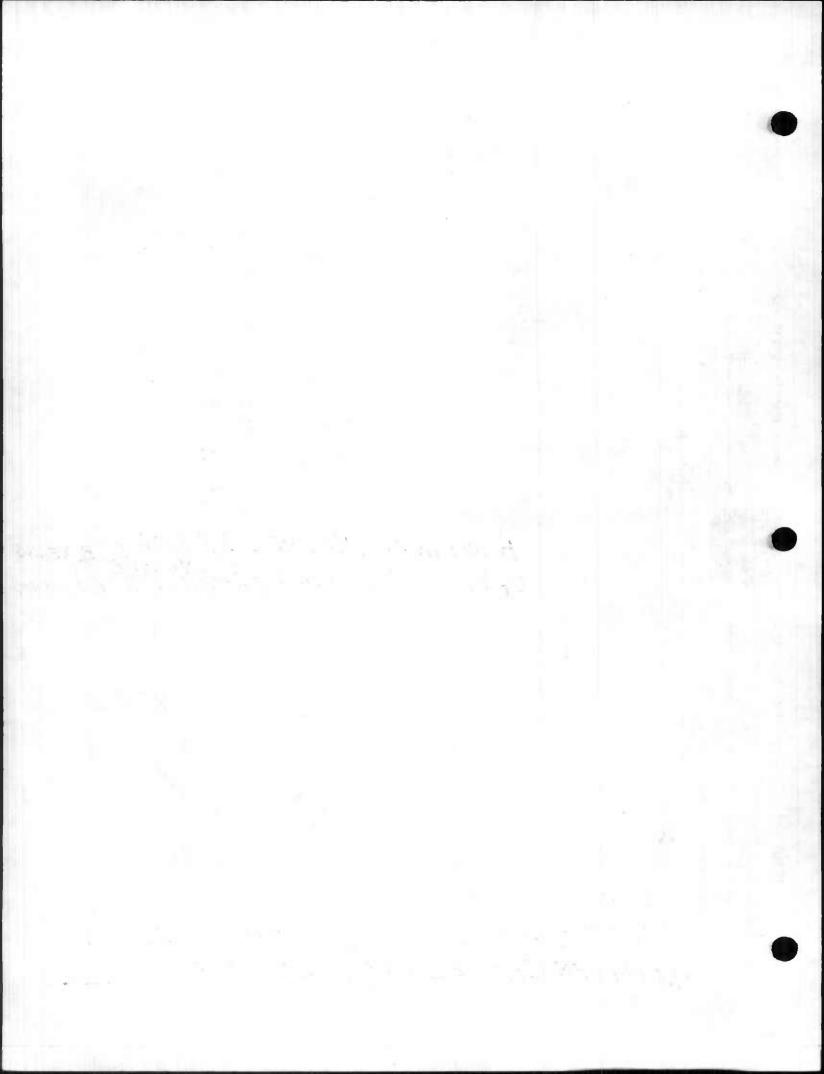
| | | 1. Decedent's Nem | - 157mm 8.82ml | Idla I and | | | | | | | | 1 0 Date - 4 Da | Reg. No. | | 10.77 | |
|--|---|--|--|--|--|--|--|---|--|---|--|---|--|--|--|---|
| Physician | | | | | 00 | | T | 7111157 | hood | | | 2. Date of De Month April | 10ay | 1999 | | ne of Death |
| /Medica | al _ | Sharon Lee Fullwood 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or | | | | | | Oh. T | • | | | / • | JO IM | | | |
| Examine | er 4 | | | | treet and nu | imber) | | | | | Baltimor | Location of Death 4c. County of Death NA | | | | |
| | | 1901 Ha 5. Sociel Security N | | 6. Sex | -X1.10 | 7 800 / | Um .um laa | t birthday) | If Under 1 Yea | | If Under 24 Hrs | | | | | |
| Funeral Director | | 213-52-4 Usuel Residence of | 121 | | M 2/X | 7. Age (| 49 | Yrs. | Months Day | | Hours Min. | | 8,1950 | Mary | land | tate or Foreign |
| aryland show id.al | 1 | 10a. Stete | 10b. Count | ty | | 1 | | Town or Lo | | Ì | | | | | | de City Limits |
| The Mi | e M | Maryland | | NA | | | Bal | ltimo | re | | | | | | , rX | Yes 2 No |
| | ō | 10e. Street and Nur 1901 Har | | ve. | | | | | 10f. Zip Code 2123 | | | | 10g. Citizen o | f What Cou | ntry? | |
| - pa and | by Fur | 11. Maritel Stetus 1 Never Marri 3 Widowed | | beined | 2. Wes Dec Armed Fo 1 Yes If Yes, Gi Yeer or D | orces? | | | Wes Decedent of If Yes, specify Cu | | panic Origin? (S , Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | Spec | ece - Ameri leck, White, white: | etc. | an, |
| Maryland 21215-0020 d 2 should be filed within 72 hours at this and Mental Hygiene. T's marked other than "natural", or traumatic event, the Medical Exam TO Be Completed by 8 | Completed | Elementery/Seco | 15. Decede ify only high ndery (0-12) | est grade | completed) |) (1-4or 5+) | 1 | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | rking | 16b. Kind of | | | 44 / 6 | |
| S years | Š | 11 | | | | | | Con | sultant | | | | | ncial | | |
| D STEP | 98 | 17. Fether's Neme (| | | | | | | | 1 | | me (First, Middle | | , | | |
| ylar Nents Ments arrised atte | 0 | Milton | Grant | Fars | son Sr | • | | | | | rvelyn | Francie | s rokun | laga | | |
| Ta Sand | 1 | 19s. Informent's Na | me/Reletion | nship (Typ | e, Print) | | | 19b. Meilir | ng Address (Stre | et an | nd Number or R | ural Route Numb | er, City or Tow | n, State, Zij | Code) | |
| | | Kim Wane | r (Da | ughte | er) | | | | 7 Edmund | | Way Ell | cridge, | MD 2107 | 5 | | |
| Ore the total | 2 | 20e. Method of Disp 1 X Burial 2 | | □n- | mount from | | 20b. Plec | e of Dispo | sition (Name of metory or other p | olece) | | Dete | 20c. Location | | | ete |
| Page nent if | | 4 Donetion | | | movel from | 31919 | Loude | on Pa | rk Cemet | ter | су | 4/23/99 | Balti | more, | MD | |
| Baltimore, permit. Pages 1 at Department of Heal Important: If them 3 any Injury or other atice. | 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility Loudon Park Funeral Home | | | | | | | | | | | | | | | |
| | | P/1- | 110 | - | | | | | | | | | | | | |
| Physician | 2 | 23a. Pert1. Enter it shock, or hee | ne disebuse, o 1 feilure. Lis | or complic st only one | | | | Do not ente | 620 Will er the mode of d | ker lying, | ns Ave. | Baltim c or respiretory e | errest, | | Approx | I Between |
| /Medical Examiner | niner | Immediate Cause (disease or condition resulting in death) | Finel n | or complic st only one e. | | Ca | NIN | Do not ente | 620 Will er the mode of d | ker lying, | ns Ave. | Baltim c or respiretory e | errest, | | Approx | I Between |
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DHMH 16 Rev 6/95

APR & 1 1999

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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Dey Year **Physician** Alice V. Franzello 11:37 a.m. 1999 April 19, /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Harford 4705 Chippewa White Hall Drive If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Sept 25 Birthplaca (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours West Virginia 074-18-3151 72 Director Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryli the Medical Examiner must be notified at White Marsh Md. Baltimore 1 ☐ Yes 2 No Director 288-1 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code or items 23a or 21162 5609 Cullum Avenue United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Merried 2 Merried 21215-0020 1 Yes 2 XNo Specify: Specify. White à 3 X Widowed 4 ☐ Divorced Year or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fit there of Health and Mental H tent: If them 27 is marked off 88 Harvey Shortridge Lydia Anderson 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health a Important: If Item 27 is any injury or other trau ODS#. Brenda S. Maenner (Daughter) 2905 Jomat Ave. Baltimore, Maryland 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Ø Cremetion 3 ☐ Removel from Stete Hilltop Service Corp. 4/21/99 Towson Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Lipensee Milton, J. Knight Jr 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21214 5305 Harford Road Baltimore, Md. 23a. Pert1. Enter the disease, or complications that caused the shock, or heert teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth eth. Do not enter the mode of dying, such as cardiac or respiratory errest, Physician /Medical Immediate Ceuse (Finel 31/2 years disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. signed by the attending physician Id be detached for use as the buria Physician/Medical Due to (or es a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by rthis certificate has been sir ral director, page 2 should? 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an eutopsy performed' 1 Yes 2 No 1 Yes 2 No septat or Attending Physicien: The hours after death, ineret Director: After this certificate by filled in by the funeral director, pa 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 8 Nother (Specify) Residence 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Phyetclan: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. edicai 29a. Certifier 29b. Signature end title of cartified 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) APR 2 1 1999

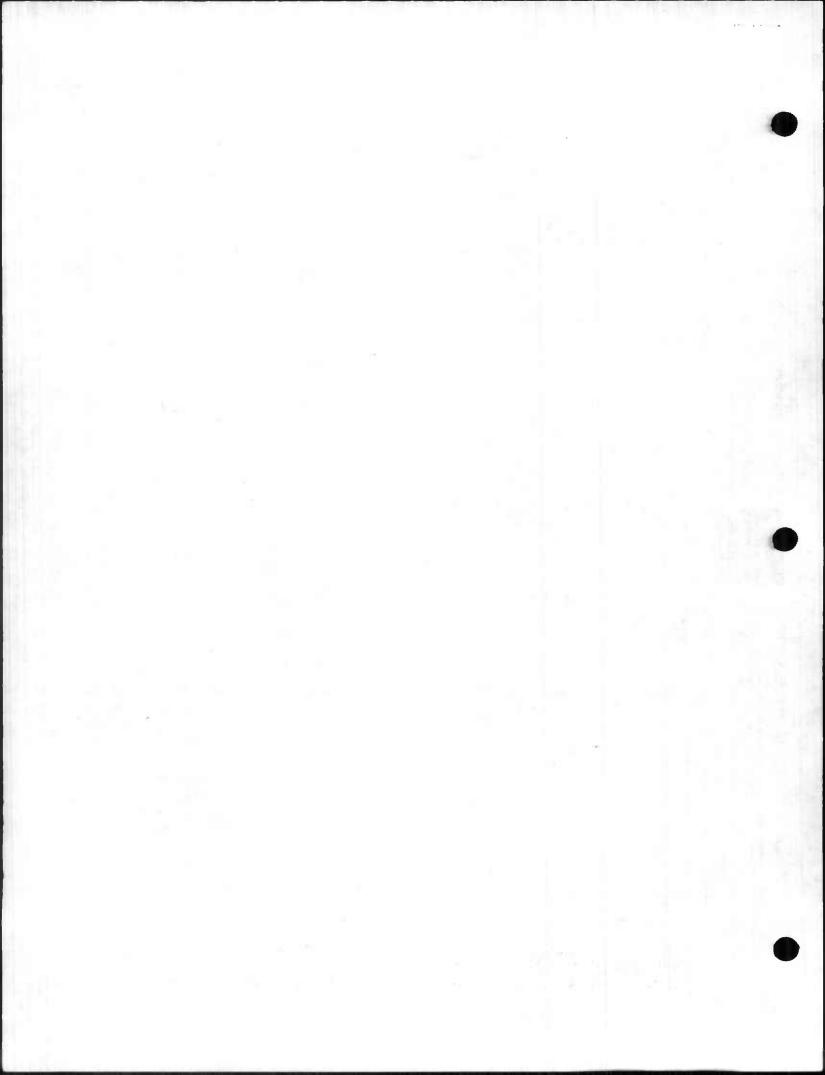
32. Registrer's Signeture

who completed cause of deeth (Item 23a) (Type, Print)

Charles Padgett, ND, S60 lock Raven Bush Boltimore, MD 21239

April 20, 1999

D15546

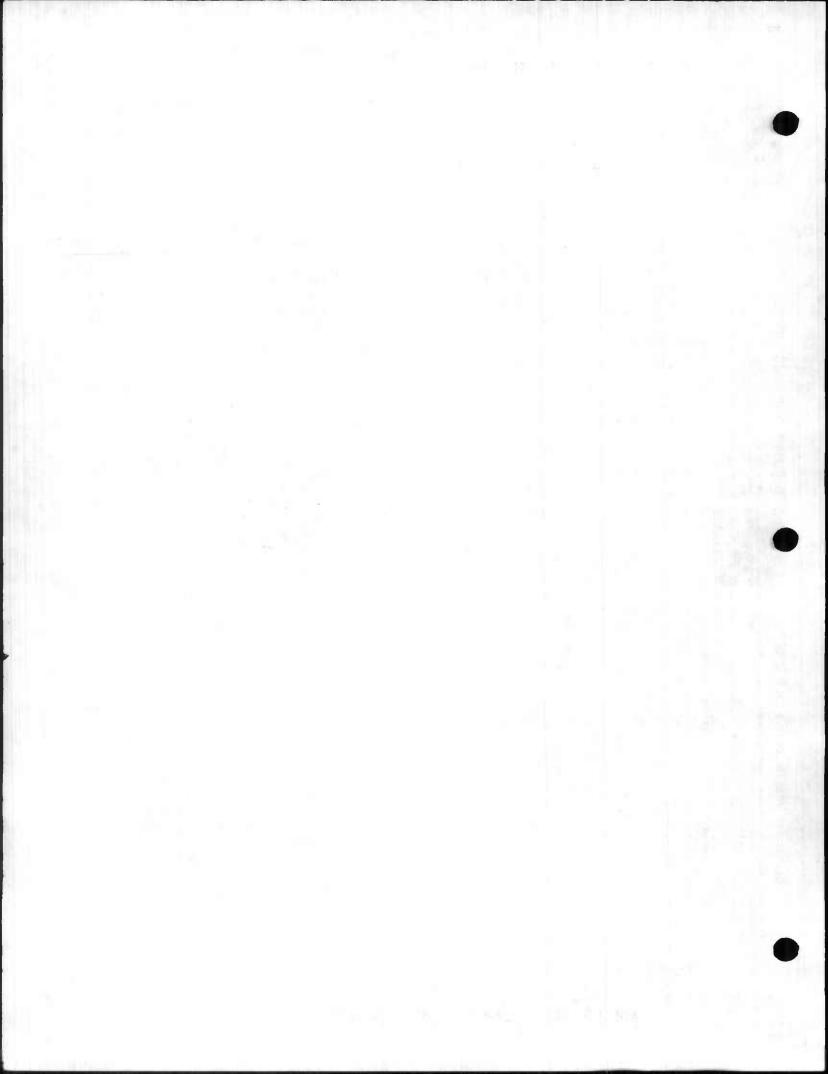


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item: 20g per F.H G-770 4/21/99 reb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1999 **Physician** APRIL 15, FLEISHMAN 3:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT HOME 8. Date of Birth (Month, Dey, Year) MAR. 14,1914 If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 200 F 213-27-8976 85 UKRAINE Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location works! 10d. Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 7920 SCOTTS LEVEL ROAD 21208 PERMANENT RESIDENT Name 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yas, Giva 1 Never Married 2 Merried altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE ğ Yeer or Detes: ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hyg.
Important: If Nem 27 is marked other any Injury or other transment other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) ag YOSIF FLEISHMAN FAYGA (UNKNOWN) 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSA MIKHAILIK / DAUGHTER 6960 MARSUE DRIVE - APT. 1C -BALTIMORE, MD 21215 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 4/18/99 BALTIMORE, MD 21. Signeture of Furierel Service License 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximeta Intarval Batween Onset end Deeth **Physician** THROMBOSIS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner buriai-fransit requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician the buria Box 68760. Physician/Medical Due to (or as e consequence of): P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Onknown Records. Completed by 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 20 No 1 Yas 20 No certificate Division of Vital Attanding Physician: Be 25. Wes case raterred to medical 26. Placa of Deeth (Check only one) Other: Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Neturel death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Hospital or Attand
 24 hours after death
 Funeral Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 3 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 1)28595 sulle m 23m (Type, Print) Balls Md 21208, 7220 we 31. Date filed (Month, Day, Year) State APR 20 1999 Registrar

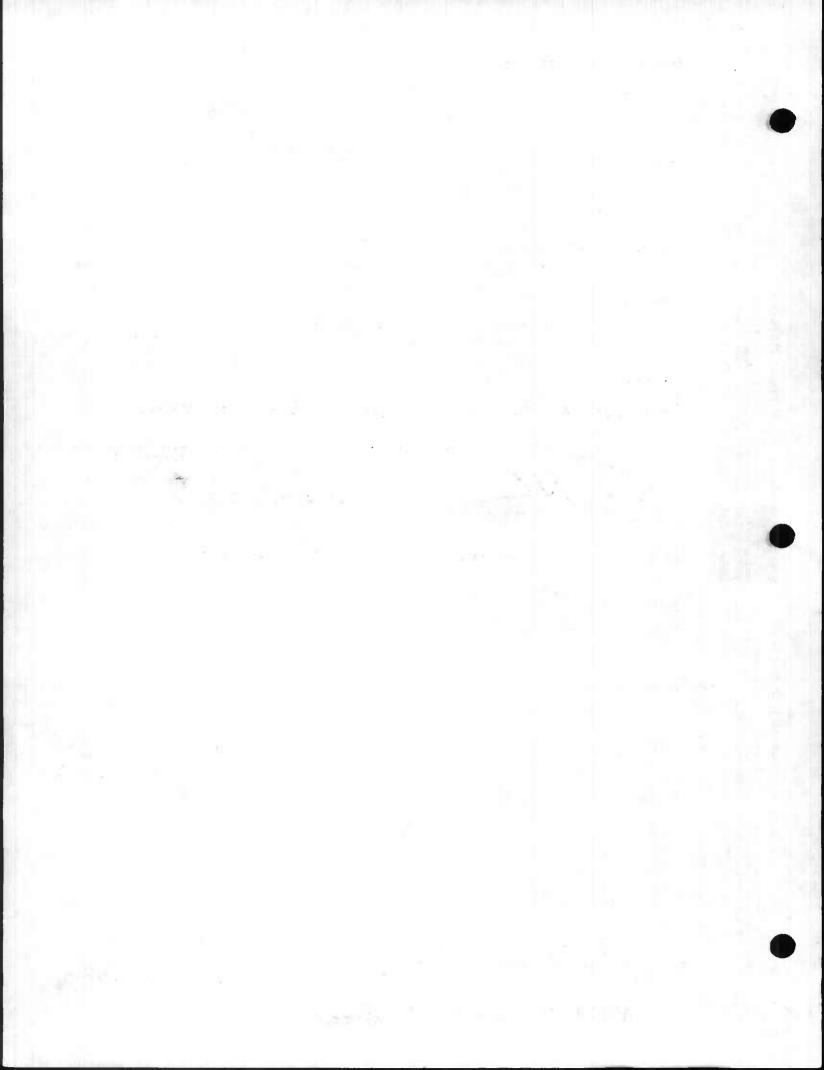
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| SIDNEY FELDMAN | Item: 20c | per F.H G- | State of I | - | | artmen | | | and M | lental Hy | gien Reg. No | 0.0 | 1 | 3008 |
|--|---|---|--|---------------|------------------------|---|------------|----------------------------------|---|--|---|--------------------|-------------------------------|--|
| Physician /Medical | 1. Decedent's Na SIDNEY | ma (First, Middle, L | ast) | FEL | DMAN | | | | | 2. Data of De Month APRIL | Da | 6, 19 | Year 99 | 3. Tima of Death 6:09P.M. |
| Examiner | | S HOSPITA | | | last hirthday | If Under | | BALT | IMOF | CE 8. Data of Bil | | County o | 'A | olaca (State or Foreign |
| Funeral Director | 384-40-C | 228 | 1½ M 2□ F | 57 | last birthday) Yrs. | Months | Days | Hours | Min. | DEC 2 | 192 | 41 | MICH | IGAN |
| deeth with the Maryland ms 23s or 28s-f ehow rmet be notified at | 10a. Stata MI | 10b. County OAKLAND | | | y, Town or Lo | | .D | | | | | | 1 | 0d. Inside City Limits 1 Yas 2 □ No |
| of the Maryle Ma | 10e. Street and N 5355 E | | LAKE DRIV | E | | 10f. Zip 483 | | | | | 10g. C | itizen of W USA | /hat Cour | ntry? |
| 5-0020 72 hours after des naturel; or items naturel material parties atted by Funer | 3 ☐ Widowed | rried 20 Married | 12. Was Decede Armed Force 1 Tes 2 If Yas, Giva Yaar or Data | s? ⊠ No | ŀ | Was Deced If Yes, spec 1□ Yes 2 | | ispanic Origin, Mexican Specify: | gin? (Spe i, Puerto | ecify Yes or No Rican, etc.) | 0- | Black | - Americ k, White, WHIT | |
| d within glene. | (Spo | 15. Decedant's lecify only highest groundary (0-12) | ducation rade completed) College (1-4d | or 5+) | (Give | Decedent's Usual Occupatio (Give kind of work done dun tite. DO NOT use retired) UER | | | durina most of workina | | | CIRIC | | CONTRACTOR |
| Maryland 212 d 2 should be filed with the and Mental Hyglene. The marked other than the unmail: event, the | JOSEPH | a (First, Middle, Las | FE | LDMAN | | | | ANNE | | (First, Middle | KA | PLAN | | |
| e, Mar 1 and 2 sho Heelth and Pm 27 is m ther treum | | Name/Relationship FELDMAN | | | 5355 | PLEAS | SANT | LAKE | DR • | W.BLO | OMFI | ELD, | MI. | 48322 |
| in Personal | | | Removal from Sta | | cemetery, crea | Disposition (Name of , crematory or other place) SHALOM | | | | Date 4/19/99 | 20c. Location - City or Town, Stat 9 FARMINGTON HILL Livonia, MI. | | | |
| Baltimo | 21. Signatura | Aneral Service Lice | | | 2. Nama an | | -200 -0010 | SO | OL LEVINSON &BROS. INC. ROAD PIKESVILLE,MD. 21208 | | | | | |
| Physician /Medical Examiner | Immediata Causi disaasa or condit resulting in death | eart failure. List onl a (Final ion | a Hyperte | nsive | | ioscle | | | | | | iseas | se | Approximata Intarval Between Onset and Death |
| P.O. Box 68760, that the deeth cartificate be executed ed by the attending physician end detached for use as the burial-transit Physician/Medical Examiner | resulting in daath | is | c | <u> </u> | or as a consec | | | | | | | | 1 | |
| 1S, P.O. Box rest that the deeth carding igned by the attending be detached for use a by Physician/M | Part II. Other sign | ificant conditions | contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unkno | | | | |
| aw requires to see a second to see a second to see a second to sec | | | | | | | | | perf | Was an autopsy performed? PECTION 24b. Ware autopsy finding available prior to completion of cause of death? | | | allable prior to | |
| Vitai clan: Ti entificate ector, pa | 25. Was case refe axaminar? | | Mosnite! | | | | Oth | | of Death | 1 Check only | Yas 2 | 2 □XNo | 1 (| □Yas 2 No |
| Division of National States of Attending Physis within 24 hours after deeth. To the Funeral Director After this completely filled in by the funeral din Medical Certification: To | 1 New 2 2 27. Mannar of Dec 1 Natural 2 Accident 3 Suicida 4 Homicida | 5 Pending Investigation 6 Could not | DB Bloom of Injury At home form street factors office. 29f Location (Street and | | | | | | ury occurr | | | | | |
| he Hospiu in 24 hours he Funeral pletely fille | | | | | | | | | | | | | | |
| To the within To the comp | 29b. Signature an | erdu H. | King. | ~> | _ | C | . C.N | number M.E. | | 7 | | ata signed | | Day, Year) |
| 9 | Theodore | e King M. | | | | | Penn | Stree | et, | Baltimo | ore, | Mary | /land | 21201 |
| State Registrar | 31. Date filed (Mo | nth, Day, Year) PR 2 0 19 | | strar's Signa | | do | elle | _ | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dafe of Deeth Dev Month Barbara J. Griffith April 15, 8:25 PM 1999 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2211 Canary Court Baltimore If Under 1 Year | If Under 24 Hra. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Months Hours 1□M 2 F Yrs. 217-66-5630 66 Oct. 16,1932 West Virginia 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 M Yes 2 □ No N/A Baltimore 10f. Zio Code 10g. Citizen of What Country? 21231 USA 13. Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, efc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Specify: White 1 Yes 2 No Specify: 16b. Kind of Business/Industry

Director Usuel Residence of Decedent with the Meryland r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Director Maryland 10e. Street and Number 2211 Canary Court Funerai 11 Merital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Heelth end Mentel Hygiens Important: If item 27 is marked other than any injury or other treumatic event, that DRCs. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Walter Gilmore Maggie Thomas 0 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph Griffith/Son 6917 Homeway Road, Dundalk Maryland 21222 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, cremetory or other place) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22 Name and Address of Facility David J. Weber Funeral Homes, P.A. Baltimore, Maryland 21231 6, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or injury that initieted events resulting in deeth) Last Box 68760 Physician/Medical Due to (or es a consequenca of): Division of Vital Records. P.O. 6

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No 24b. Were eutopsy findings available prior to 24a. Waa en eutopsy performed? completion of cause of death? 2 (No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Netural 2 Accident 5 Pending 1 Yes 2 No investigetion 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and little of certifier

29c. License number 29d. Dete signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Neme and add ARRENAR

S Broadway Bollo 21231

Domestic

Maryland

4/20/99

20c. Location - City or Town, State

Approximete Intervel Between Onset and Deeth

State Registrar

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To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

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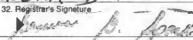
Physician

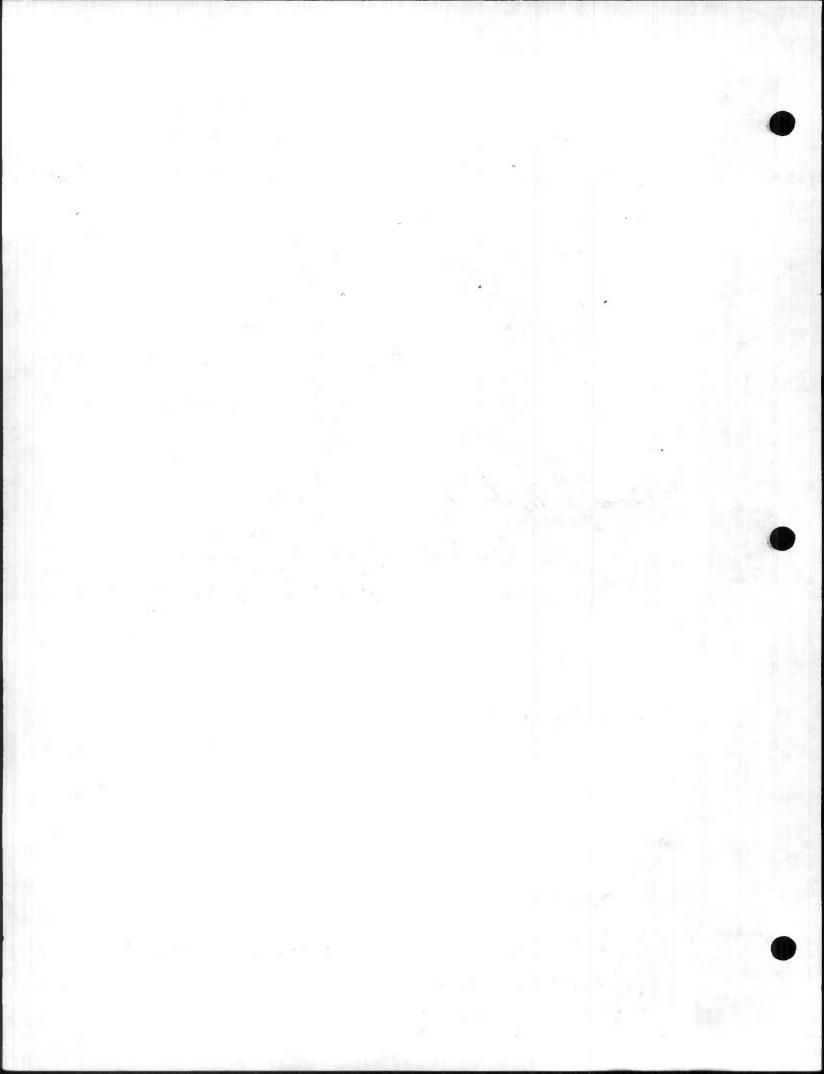
/Medical

Examiner

Funeral

onth, Dey, Year) APR 21





Anil Rila Flages

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State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4b. City, Town, or Location of Death RRIE HAUES 1999 ATI 12:15a.m. /Medical P09#-4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hunder 24 Hrs. 8. Date of Mount Avenue WEST Koya I 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 A F 214-40-9390 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer death with the Maryland neat of Health and Mental hyglene.
Intr. if them 22 is marked other than "returef", or items 23s or 23s-f show ury or other treumstice avent, the Medical Experiment has notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No MD Daltimore Funeral Director NA #909 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? HUENUE 21217 USA 1600 West Houst Koyal 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: 21215-0020 Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPI URSES 12+N Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) HRRIE illiam Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McNei SISTER 4847 Wainweight Circle Uw. ngs Mills, mo Kuth E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or page. 4.24.89 Not Men. Laurel 4 ☐ Donation 5 ☐ Other (Specify) Yark 22. Name and Address of Facility

March Funera

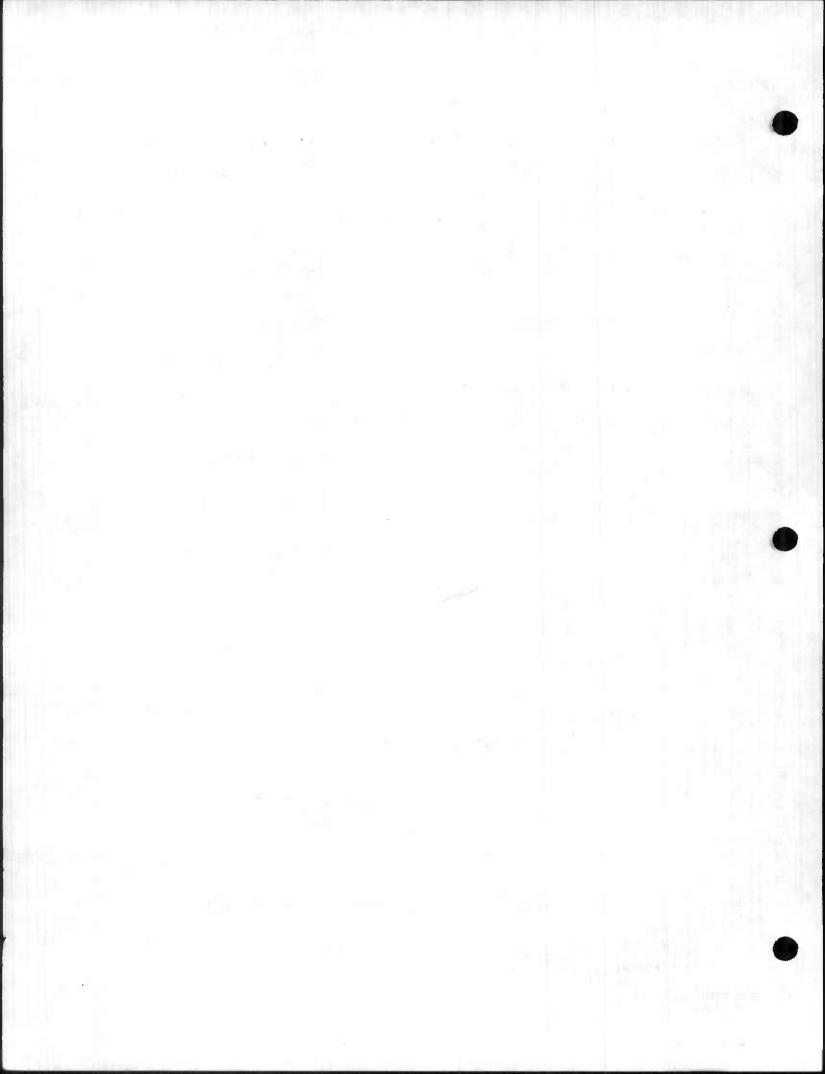
4300 wash 21. Sig e of Funeral Service Lines INC tome West Marc Balto 21215 Ane 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, short, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 710 years Physician/Medical Examiner been signed by the strending physician and should be deteched for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 1 Yes 25 No 3 Probably 4 Unknown 24b. Ware autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of cause of daeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case refarred to medical examiner? 8 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Natural 5 Pending investigation 24 hours after death.

Funeral Director: Al 1 Yes 2 No the 2 ☐ Accident 6 Could not be detarmined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 4 119199 1719873 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5356RE15 TERS TOWNED. BALTIMORE M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month 4 Day 99 6a.m. Walter H. Holland 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore NA Genesis Homewood If Under 1 Ye 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) M.d. 7. Age (In yrs. last birthday) Months Devs Hours Min MM 20 F Md 215-03-0257 Yrs. 87 Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Md 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 1819 Druid Hill Avenue 21217 S A 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ANO If Yes, Give Yeer or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 💢 Married Black 1 Yes 2(XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry HOUSING Authority City of Baltimore 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 1st Class Engineer years 17 Father's Nema (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Unk 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Holland - Wife 1819 Druid Hill Avenue Baltimore, Md 21217 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete King Memorial Park 4-22-99 Randallstown, Md 4 Donetion 5 Dother (Specify) 21. Signeture of Funeral Service Licensee 22. Nema end Address of Fecility March F/H West 300 Wabash Avenue Baltimore, Md 21215 4300 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) SEPSIS Due to (or es a consequence of) 4FU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Lest Due to (or es a consequence of): Dua to (or es a consequence of): Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown JEAJEIG MAJUJCAN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 20100 1 Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending invastigation 1 Maturel 1 Tyes 2 No 2 Accident

Examiner The law requires that the death certificate be axecuted the buriel-transit and Box 68760. Be Completed by Physician/Medical for use as Division of Vital Records, P.O. page 2 should certificate has or Attanding Physician: funeral director. Certification: To After this

Physician

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Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.
ant: If item 27 ie marked other than "naturel; or ite ury or other traumetic event, the Medical Exercises

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Physician

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Funeral Director

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21215-0020

Baltimore, Maryland

To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun edical 10 State

29b. Signetura and title of certifier

3 Suicide

29a, Certifier (Check only one)

4 Homicide

6 Could not be determined

IN

29c. License number 247945

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Dey, Year)

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Location (Street end Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (flem 23a) (Type, Print)

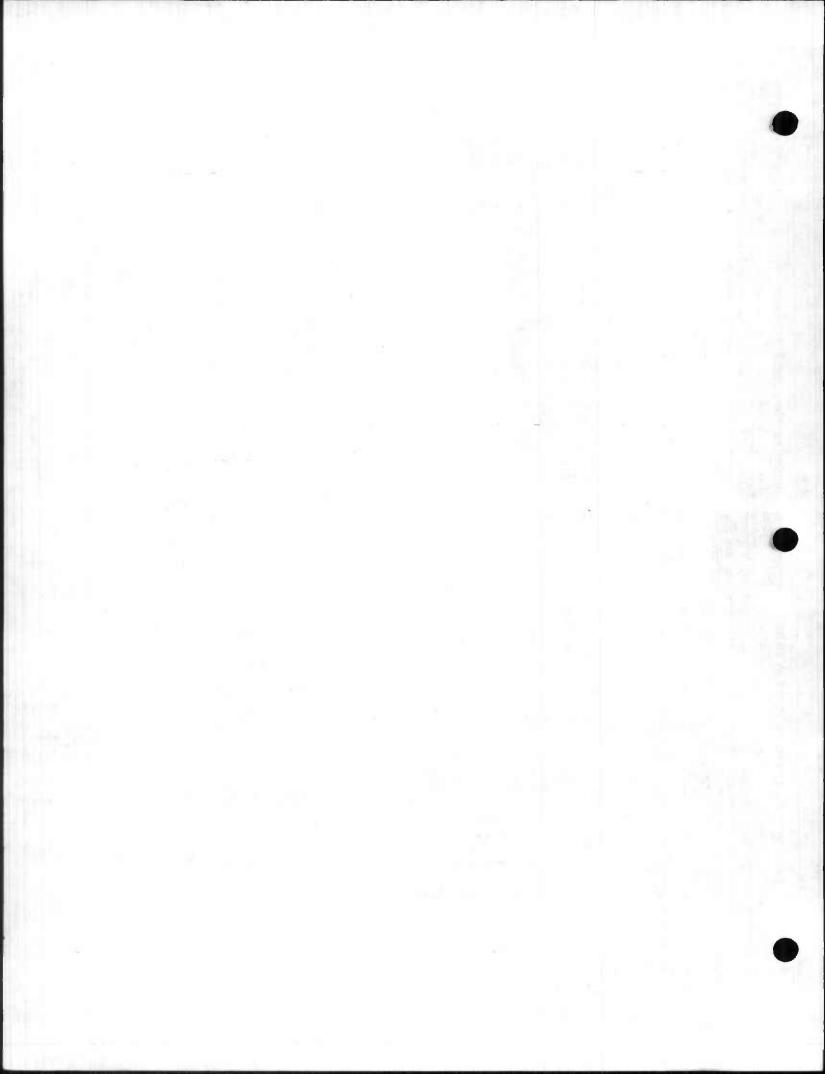
lans. Aleem Northan E 00

an kency 21214

31. Date filed (Month, Day, Year)

37 Registrar's Signature APR 2 1 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Margaret Bryden Harrison 1999 April 16 8:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 210 F Hours August 6,1918 Director 577 05 9891 80 Scotland Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Maryta 1 ☐ Yes 2 ☒ ※ Yo Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 805 Coachway 21401 Barna 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 220 No If Yes, Give Year or Dates: 72 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: À 3€Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important if Nem 27 is merited other the
any injury or other traumatic 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Hamilton Bryden Jane Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Ann Gilbreath Daughter 805 Coachway Annapolis Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) April 200 ate 199 920c. Location - City or Town, State 20e. Method of Disposition 1 □ Burlal 2 □ Cremetion 3 □ Removel from Stete
4 □ Donation 5 ☑ Other (Specify) Entombment Fort Lincoln Mausoleum Brentwood Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service Library 16000 Annapolis Rd. Bowie Maryland MARK complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examine Due to (or as a consequence of): Examine physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. à 1 Yes 2 No 3 Probably 4 Unknown been signed t should be det Records, by The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 s 1 Yes 2 - No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 8 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 → edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending Investigation death. 1 Yes 2 No hours after death. uneral Director: A ity filled in by the fi 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State 31. Date filed (Month, Day, Year)
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30. Nama and eddress of person

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State of Maryland Department of Health and Mental Hygi

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| | Directo |
| nore, Maryland 21215-0020 | ages 1 and 2 should be Illed within 72 hours efter desth with the Maryland nt of Health and Mantai Hygiene. It if them 27 is marked other than "natural", or thems 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at |

HARRIS ITEMS: #23 PART I, 27, 28A-F PER MEO G770 4-22-99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** APRIL 16, 1999 Bruno Harris 3:02 PM. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1218 N. AUGUSTA AVE. BALTIMORE N/A | Winder 1 Year | Winder 24 Hrs. | 8. Dete of Birth (Month, Day), Year | Min. | Mar 27, 1960 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F 39 Yrs. MD 216-76-2554 Usual Residence of Decedent 10b. County 10a. Stete 10c. City. Town or Location 10d. Inside City Limits Yes 2 No MD N/A Baltimore Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21229 1218 N. Augusta Avenue Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indien. Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: à Brack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Welder Elementery/Secondery (0-12) College (1-4or 5+) Laborer 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Delores Boyd James Henry Harris 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 N. Augusta Ave., Baltimore, MD 21229 Ms. Christine Wilson/Sister Apr 21 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 1999 Baltimore, Baltimore Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility
Calvin L Williams Funeral Service 0 3707 Colborne Road Baltimore, MD allen 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immedieta Cause (Finel NARCOTIC AND ALCOHOL INTOXICATION diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner physicien end the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 88 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 6 1 Yes 2 No 3 Probably 4 WUnknown signed t Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peen completion of cause of death? has page 2 12 Yes 2 □ No 1. Yes 2□ No certificate Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? AT Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) this SCENE 28a. Dete of Injury Four (Manth, Day Year) 27. Menner of Death 28b. Time of P 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Fourtgiury or Attending 1 Naturel 5 Pending 1 Yes 2 No death. investigation SUBJECT INGESTED DRUGS AND ALCOHOL n 24 hours after death the Funeral Director: A pletely filled in by the f 4-16-99 2 Accident 2:30 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 1218 N. AUGUSTA AVE. 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide FOUND AT HOME Hospitai BALTIMORE, MD. edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as steted. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number

State Registrar Stephen S.
31. Dete filed (Month, Day, Year) APR 2 1 1999

5.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radentz

32. Registrar

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

APRIL 17, 1999

Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 99 1214 AM Apzil UDREY MAMMETT /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Hospital Battimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Deys Months 1 M XXF 214.24.6755 71 FLORIDA 9/30/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e State 10b. County 1 Yes XX No Director ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 209 RIDGLEY AVENUE U.S.A. 21061 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify Specify: WHITE þ XX Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11 OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be PERCY PADGETT ETHEL HIGGINS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) S. GAIL OBERT - DAUGHTER 333 MARGATE DRIVE, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Burlat 2 Cremetion 3 Removal from State CRESTLAWN MEM. PARK. 4 Donation 5 Other (Specify) 4/20 SYKESVILLE, MD KELLY CRECORY FINK 11. Enter the disease for complications the mast failure less only give cause FINK FUNERAL HOME, P.A. 22. Name end Address of Fecility 426 CRAIN HWY... S.W. GLEN BURNIE, MD 21061 leations that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, to cause on each line. Approximate Intervel Between Onset end Death Immediate Clause (Final disease or condition resulting in death) neumonia Breast with metastasis Examiner 65 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No Kenal failure þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy Completed 2 No 1 ☐ Yes 2/1 No 1 Tyes 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 27. Manner of Death 28b. Time of 5 Pending Investigation 1 D Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

physician and the buriel-transit that the death certificate be executed signed by the a The law requires

Funeral

Director

Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interfer them 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examinating the notified at

Department of Important: If It any Injury or o

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, attending pl s certificate has b director, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

> State Registrat

Medicai

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

A. Cheshi MO

APR 2 1 1999

29c. License number

0 8859

Let's retifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29d. Dete signed (Month, Day, Year)

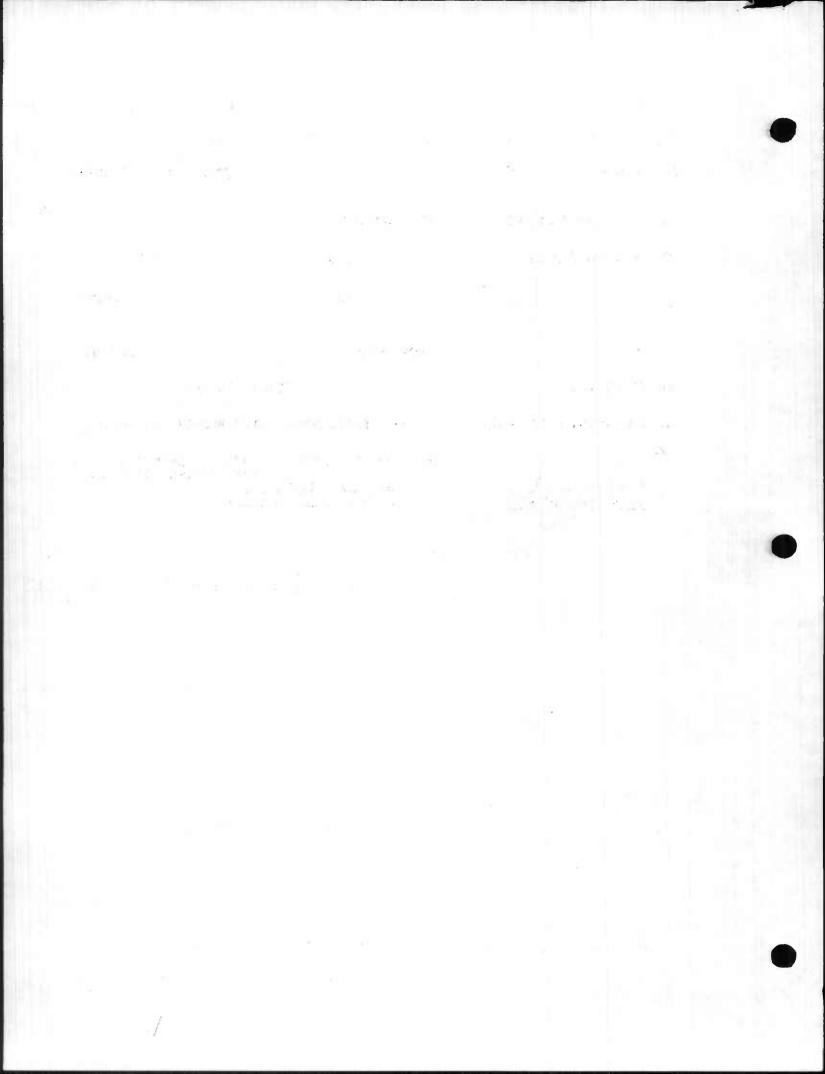
30. Name and address of person who completed cause of death (Item 230) (Type, Print)

Aurochi. Harbor Hospital Center, Baltimore, MD

31. Dete filed (Month, Day, Year)

32. Begistrer's Signeture

DHMH 16 Rev 6/95

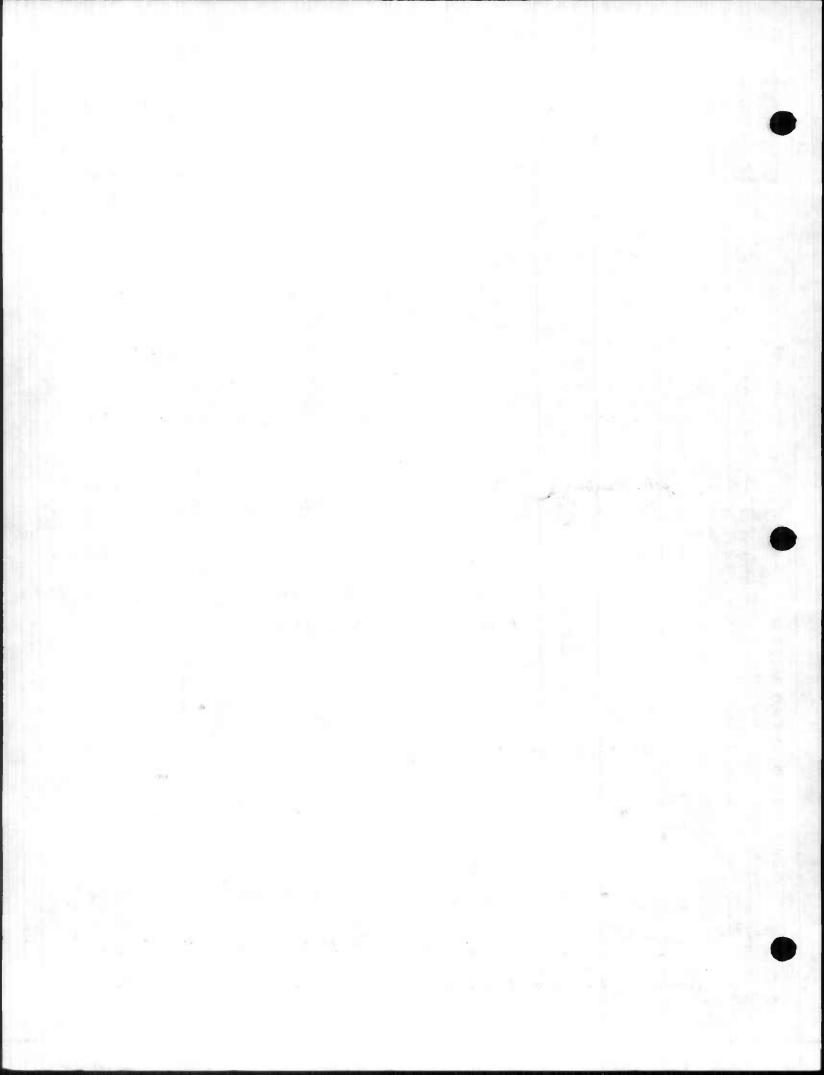


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date | Reg. No. | 3. Time of Death | | |
|--|---|---|--|--|--|
| Physiciar | | h Day | Year 7.15 | | |
| /Medica | Ab City Town or Location of a street and supplied | | of Death | | |
| Examine | MARINER HEALTH OF GLEN BURNIE GLEN BURNIE | | ARUNDEL | | |
| Funeral | 5 Social Security Number 6 Sey 7 Age (In yes last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date | of Birth | Birthplace (State or Foreign Country) | | |
| Director | 217.14.0510 1 M 2 75 Yrs. Months Days Hours Min. (Mont 5/2) Usual Residence of Decedent | 9/1923 | MARYLAND | | |
| death with the Maryland rms 23a or 28a-f show rmsst be northed at | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits 1 ☐ Yes XX No | | |
| vith the Mai | 10e. Street and Number 10f. Zip Code | 10g. Citizen of V | /hat Country? | | |
| 234 or | | U.S.A. | | | |
| Urs after Urs after Ur, or he | 3 X Widowed 4 □ Divorced Year or Detes: | | a - American Indian, k, White, etc. : WHITE | | |
| ind 21215-0020 be filed within 72 hours af tal Hygiene. d other than "natural", or event, tre Hodical Exert | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | | siness/industry | | |
| filed within Hygiene. | ASSOCIATE ASSOCIATE | ALLSTA | | | |
| Maryland d 2 should be file ith and Mental Hy 77 is marked oth traumatic event | 17. Father's Neme (First, Middle, Last) AUGUST H. SCHLOTE 18. Mother's Name (First, Middle, Last) JOHANNA SCHLU | | Θ) | | |
| S should and Me | 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route I | Number, City or Town, | State, Zip Code) | | |
| e, Mé | JOHN H. HESS - SON 516 DOGWOOD DR., S.W., GLEN | | | | |
| Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than any injury or other traumatic event, the Mode. | 20a. Method of Disposition 1 | | City or Town, Steta | | |
| it. P. | 4 Donetics 5 Other (Specify) 10UDON PARK CEMETERY 4/21 21. Support of Juneal Service Lightness of Facility FINK FU | BALTIMO | | | |
| Baltis permit. P Department important any injure | 426 CRAIN HWY., S.W. GLEN BURNIE, MARYLAND | | , r.A. | | |
| Physician | 23a. Pert1. Enter the distance or included in the caused the deeth. Do not enter the mode of dying, such as cardiac or respirate shock or heart failure. List by one cause on each line. | lory errest, | Approximete Interval Between Onset end Death | | |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in deeth) a. MULTERIE STROKES | | WEEKS YEARS YEARS | | |
| De is | Due to (or as a consequence of): ATHEROSCLERUS ZS AND | | YEARS | | |
| physician and sthe burist-transit | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury | | VENNS | | |
| | | | 101110 | | |
| P.O. BOX hat the death cert d by the attending leteched for use a | d | | | | |
| hat the de detached detached | Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | 23b. Did tobacco use contribute to the cause of d | | | |
| The law requires that the death certificate has been signed by the attending page 2 should be detached for use a | DYS LEPISEN IA | Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| The The Page | | 1 ☐ Yes 2 €No | 1 ☐ Yes 2 ☐ No | | |
| VICAL: The certificate rector, pag | 25. Wes case referred to medical exeminer? 26. Place of Death (Check | only one) | | | |
| hysic his ce | | Residence 6 Oth | er (Specify) | | |
| ng Ph therthi | 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of lighty 28c. Injury at Work? 28d. Des | red | | | |
| To the Hospital or Attending Physician: The Iswithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office 28f. Loca City. | er or Rural Route Number, | | | |
| To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Cell. | | o the cause(s) and ma time, date end place, | nner es stated. and due to the cause(s) | | |
| the the make | | 29d. Date sinner | 1 (Month, Day, Year) | | |
| F 3 F 8 | 1750 Hm 10991 | A PUBLISHED | The second secon | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis Rose, HD. Sugs 500 200 / Spage Drace Grea Busses M. | 4-19 | 71 | | |
| | Daves Rose, HD. Sugs 500 200 /possegge Drace Ocea Duras My | surges 2 | 106/ | | |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registrer's Signature | | | | |

DHMH 16 Rev 6/95

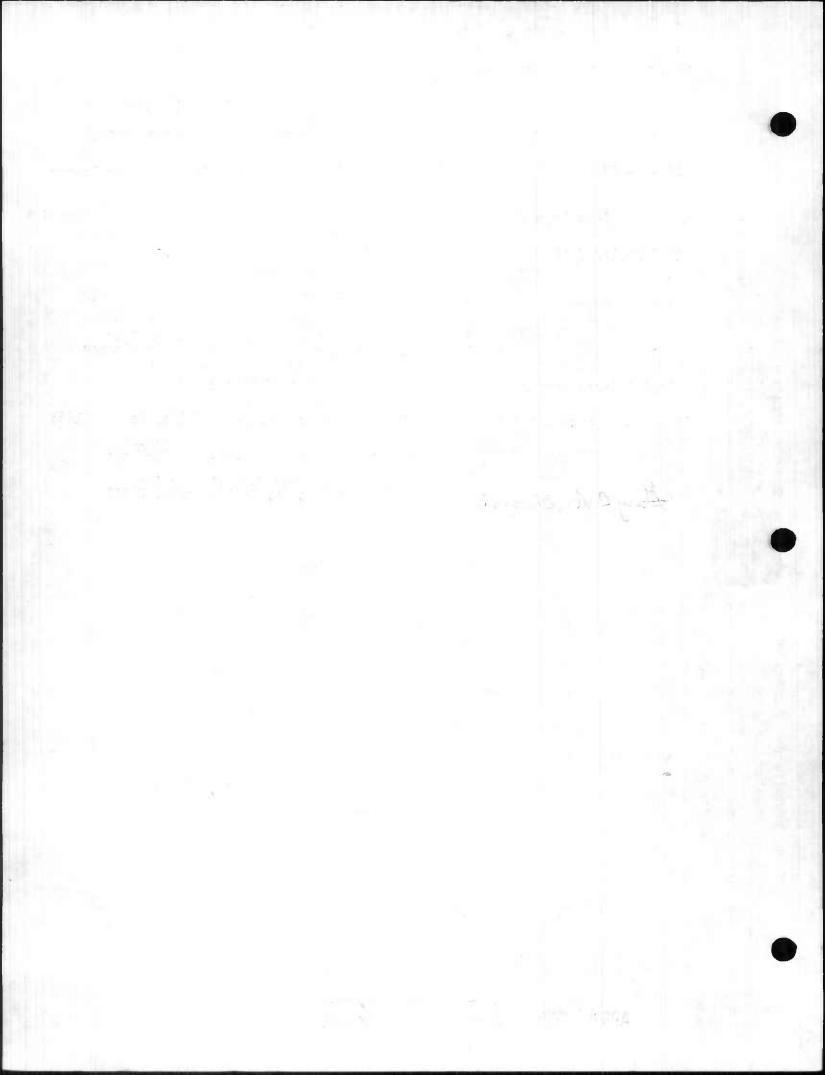


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

| | Item: 26 per M.D G-770 4/21/99 reb Certificate of Death | Reg. No. |
|--|--|--|
| Physiciar | 1. Decedent's Nama (First, Middle, Last) Richard Daniel Hogans | 2. Data of Death Month Day Year 04 15 1999 3. Tima of Death 12:57 p.m |
| /Medica Examine | | Location of Death 4c. County of Death |
| Funeral Director | 5. Social Security Number 217-26-4529 6. Sex 10 M 2 F 7. Aga (In yrs. last birthday) 70 Yrs. 10 Months Days Hours Min | |
| Mand Mand | 10a. Stata 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| vith the Mar t or 28a-f at the noun ad | Md. Anne Arundel Annapolis | 1 ☐ Yas 2X☐ No |
| after death with the Marylar or Items 23s or 28s-f show infrest mast be notified at | 10e. Street and Number 2985 Poplar Trail 21401 | 10g. Citizen of What Country? USA |
| 0 5 4 4 | 3 ☐ Wildowed 4 ☑ Divorced Year or Datas: Konean 1 ☐ Yes 2 ☒ No Specify: | Specify Yas or No- to Rican, atc.) 14. Race - American Indian, Black, Whita, atc. Specify: White |
| d 21215-0020 filed within 72 hours at thysiens. ther than 'netural', or out, the Medical Exern | 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of wo | Lawn Mower Distributor |
| and 212 be filed with that Hyglena. d other than avent, tree | | nma (First, Middle, Maiden Surname) |
| arylan should be nd Mental marked o umaric av | Daniel Ayres Hogans Ruth El | lenor Olbon |
| - CI | | tural Route Number, City or Town, State, Zip Code) Great Falls. Va. 22066 |
| Ore, of Heal of Heal of Heal | 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Gramation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data 20c. Location - City or Town, Stata Timonium Maryland |
| Baltimore, permit. Pages 1 a Department of Hee Important: If ham any injury or othe ance. | | Funeral Home Inc. Baltimore, Md. 21214 |
| | 23a. Part I. Enter the disaase, or complications that caused tha death. Do not enter the mode of dying, such as cardie shock, or heart failura. List only one cause on each lina. | |
| A 68760, enflices be assected find physician and as the burlat-transit as the burlat-tra | Cause (Disease or Injury that initiated evants resulting in death) Last Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): | |
| BOX beath cert attendin for use | Death Other starting and starti | |
| requires that the death certification is a strong from the strending hould be detached for use a stand by Physician A. | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| The law requires that the law requirements the law requirements that the law requirements that the law requirements the law requirements the law requirements that the law requirements that the law requirements the law requi | | 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? |
| vital Re lician: The lav certificate has rector, page 2 | | 1 Yas 2 No 1 Yas 2 No |
| Of VICE Physician: this certific ral director. | 25. Was casa rafarred to medical examinar? Hospital: 26. Place of De | eath (Check only one) |
| T dist | 1 Yas 2 No | Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 28d. Describe how injury occurred |
| DIVISION To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification: | 3 Suicide 4 Homicide 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| n 24 hour n 24 hour ne Funera pletely fill. | 29a. Certifier (Check only onl) 2 Medical Examiner: On the basis of my knowledge, death occurred at the tima, data and place of axamination and/or invastigation, in my opinion, death occurred. | e, and dua to tha causa(s) and mannar as stated. urred at tha time, data and place, end dua to tha causa(s) |
| To the within 2 To the comple | 29b. Signature and title of certific 29c. License number 29c. Lice | 29d. Data signed (Month, Day, Year) 4/19/99 |
| | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) | napolis, MD 21401 |
| State Registrar | 31. Data filed (Month, Day, Year) 32. Regionac's Signature APR 2 1 1999 Region APR 2 1 1999 | |

3



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 19b per F.H G-770 4/21/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea DONALD HOWARD HOROWITZ APRIL 1999 15, 08:45 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1⊠M 2□ F Months Hours 219-32-6477 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 FALLSTAFF ROAD #42 21209 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) ACCOUNTANT DEPT. OF SOCIAL SERVICES 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumeme) **JACK** HOROWITZ BERTHA BELSON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Ratationship (Type, Print) LEONARD HOROWITZ / BROTHER 480 LA MASA COURT - PORTOLA VALLEY, CA 94028 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 4/19/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finai REFRACTORY CONGESTIVE HEART FAILURE 8 DAYS disaase or condition resulting in death) Due to (or as a consequence of): DILATED CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 2000 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

41410

29d. Date signed (Month, Day, Year)

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician and the buriel-frensit d for use as t signed by the e s certificate hes b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director funeral filled in by 24 hours a

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

Peges 1 end 2 should be filled within 72 hours efter death with the Meryland nent of Health end Mental Hygiene and of Health end Mental Hygiene and the marked other than "natural", or items 23s or 28s-1 ehow any or other traumatic event, the Medical Exeminating and any or other traumatic event, the Medical Exeminating the notified at

Depertment of Important: If any Injury or

Physician /Medical

Examiner

Examiner

Physician/Medical

by

Completed

2

Certification:

edicai

4 Homicide

(Check only one)

29b. Signeture end title of certifier

29a. Certifier

Baltimore, Maryland 21215-0020

State Registrar

completely

within 2 To the ŝ

DHMH 16 Rev 6/95

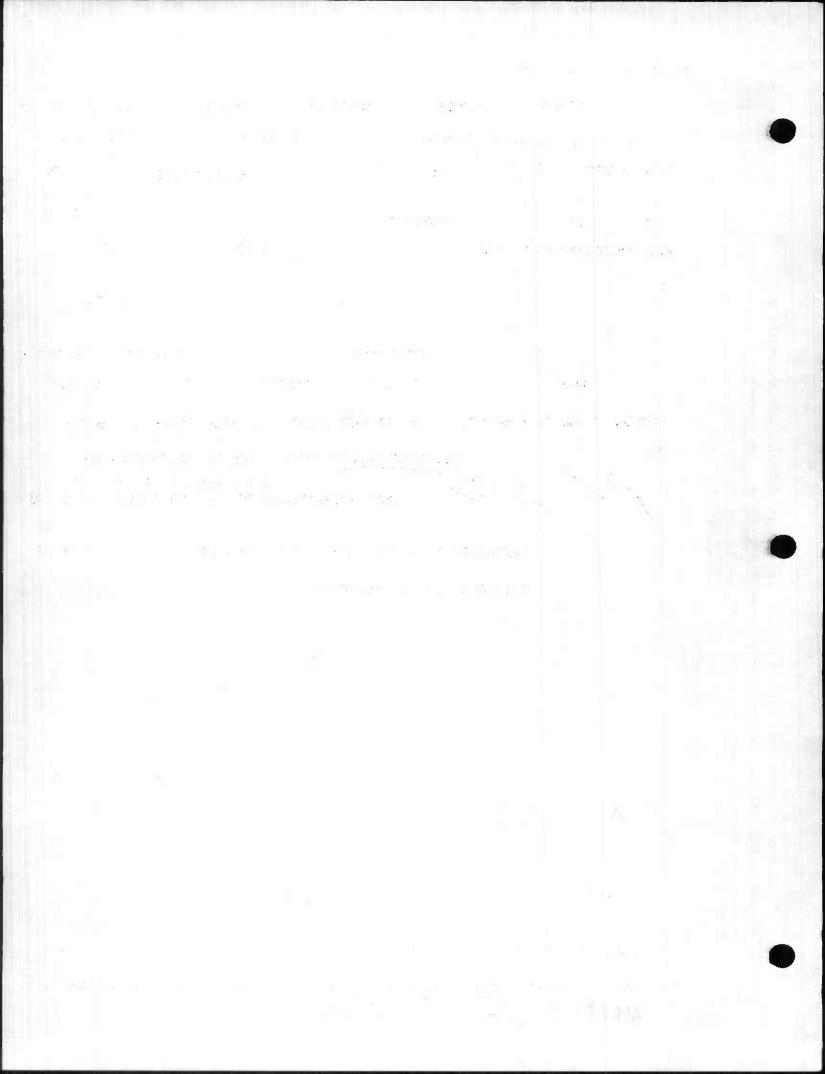
0

JOGINDER P. OSLER DRIVE TOWSON, MARYLAND 21204 M. D. 7601 MEHTA. 31. Date fited (Month, Dey, Year)
APR 2 0 1999

30. Name and address of person who completed ceuse of death (ttem 23a) (Type, Print)

malter m.o

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item: 19a per F.H G-770 4/21/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician EVELYN** TAPOLOW 1999 APRIL 16 1:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign
Country) **Funeral** Days 1□ M 2X F Months Hours Yrs. 215-22-8702 Director PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at BALTIMORE N/A MD 1 No 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21215 AVE. APT. 106 2500 W. BELVEDERE Neme 23a USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mental hygiene. Important: if item 27 is marked other than "natural", or hen eny injury or other treumatic event, the Medical Estimate DRGS. Black, White, etc. 1 Never Merried Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Rusiness/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) CALMEN SAMUEL ROSE ADI.ER 19a. Informent's Name/Reletionship (Type, Print)
ARLENE LEVIN/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5799 GRAND HARBOUR CIR. BOYNTON BEACH, FL 33436 Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Removal from State 4/18/99 BNAI ISRAEL BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part / Enter the disease, or configuration that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physicien and s the burisi-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): 987 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy certificate hes 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Weturat n 24 hours effer death.

Ne Funeral Director: Afficiely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signatury and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 23767 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVE., DEBRA S. WERTHEIMER, MD BALTIMORE, MD 21215 31. Date filed (Month, Day, Year)

State Registrar

APR 2 0 1999

32 Registrar's Signature

Sporks

the state of the s special frame. - manage

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician ABRAHAM** HUTTNER APRIL 16, 1999 1:15 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL BALTIMORE N/A 6. Sex 1 M M 2 □ F ti Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Yrs. 102-16-8819 JAN 22,1922 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No MD N/A Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2837 BANNEBERRY COURT 21209 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MANAGER TEXTILE INDUSTRY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be MENACHEM MENDEL HUTTNER RAIZEL ROSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2837 BANNEBERRY COURT - BALTIMORE, MD LILY HUTTNER / WIFE 21209 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 MRemoval from State 4 ☐ Donetion 5 ☐ Other (Specify) MT. HEBRON CEMETERY 4/18/99 FLUSHING, NEW YORK 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed?

Physician /Medical Examiner

Funeral

Director

munitibe n

flams 23a

the Medical Examiner filed within 72 hours after

Hygiena. other than

. Pages 1 and 2 should be fit thront of Health and Mental H tant: If Nem 27 is marked off jury or other traumatic even

Department o Important: If any injury or

the Maryland r 28a-f show .notified.at

Baltimore, Maryland 21215-0020

use as the buriel-transit be detached page 2 certificate director. this funeral : After t

The law requires that the death certificete be axecuted

Box 68760,

P.O.

Division of Vital Records,

Physician:

or Attending

s after death.

To the Hospital or within 24 hours at To the Funeral D

the

filled in by

completely

Physician/Medical Examiner þ Be Completed Medical Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

29a. Certifier

(Check only one)

an

29b. Signature end title of certifier

Natural 2 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

Hospital: 1 Inpatient

28b. Time of

Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3□ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

26. Placa of Deeth (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Flurel Route Number, City or Town, Stete)

1 Yes

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

30. Mame and address of person who completed cause of death (ttem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

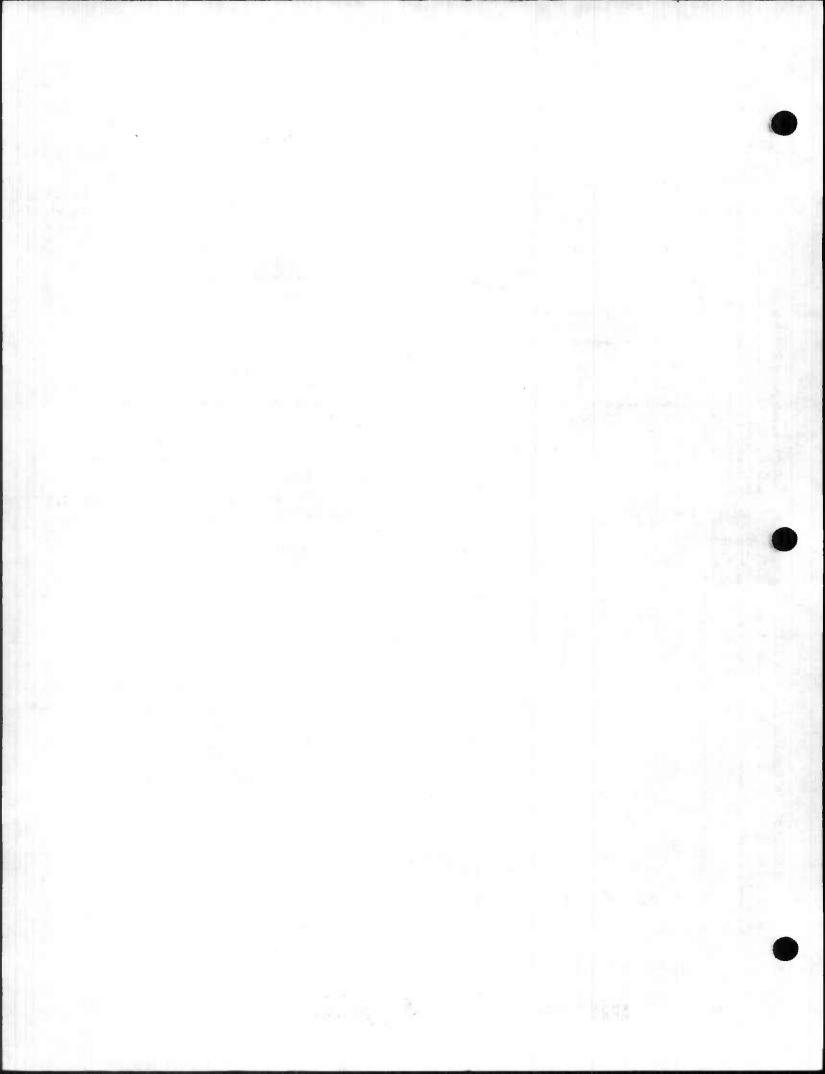
State Registrar

31. Date filed (Month, Day, Year)
APR 2 0

32. Registrar's Signature

28c. Injury at Work?

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

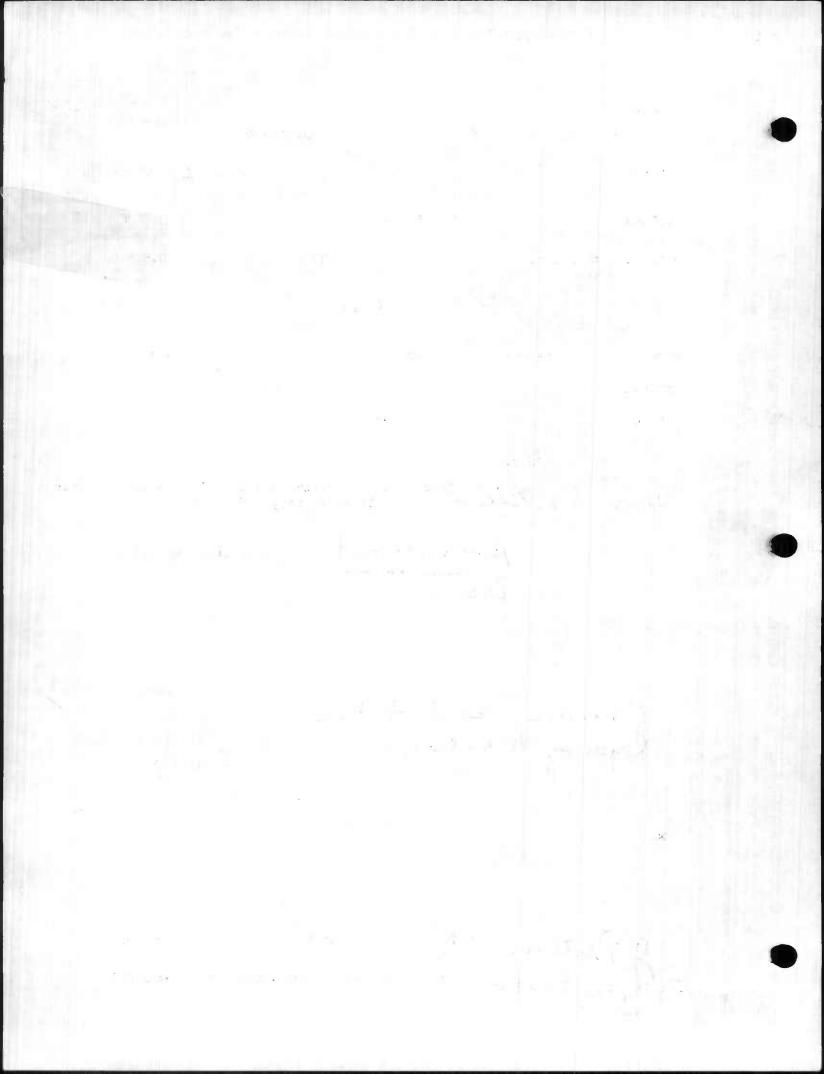
BERNARD HILL Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 1999 11:07 AM MARCH 13, Bernard Hill · /Medical 4e Fecility Neme (If not institution, give street and number)
110 WEST NORTH AVENUE R 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ROOM#102 BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year II Under 14 Hrs.

Months Days Hours Min. 5. Sociel Security Number 8. Data of Birth (Month, Day, Year) Birthpleca (Stete or Foreign Country) **Funeral** 1 XM 2□ F 51 Yrs. August 22,1947 unknown Director unknown Usuel Residence of Decedent the Marylend r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? itam 27 is marked other than "naturel", or items 23s or other traumatic event, the Modical Examinations to a U.S.A. 4 N. Central Avenue 21202 e filed within 72 hours after death val Hygiene.
other than "naturel", or items 23 Funerai 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus unknown Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify:black py 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown permit. Peges 1 and 2 should be file Department of Health end Mental Hy, Important: if item 27 is marked othe any injury or other traumatic avanta 18. Mother's Name (First, Middla, Maidan Sumema) 17. Fethar's Neme (First, Middla, Last) unknown unknown 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Placa of Disposition (Neme of cemetery, cremetery or othar piece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 X Other (Specify)in state 21. Signature of Fyneral Service Licensee 22. Name end Address of Fecility Ronald Wade, Director State Anatomy Board, 655 W. Baltimore Street Male Baltimore, Maryland 21201 231 Furt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, muck, or heart failure. List only one cause on each lina. Approximete Intervel Between Onset end Deeth **Physician** eriosclerotic /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner ease ettending physicien end I for use as the buriel-transit certificate be executed Sequantielly list conditions, if eny, leeding to immadiete cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es a consequence of): Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Dua to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown signed by 1 Yes 2 No Records, p 8 24b. Were autopsy findings eveilable prior to completion of cause of death? hemodial Completed 24e. Wes en eutopsy performed? peen Inspection hes 1 Yes 2 No Division of Vital Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 When (Specify) AT SCENE 10 XXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Neturel 5 Pending i or Attending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide Hospitai 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the causa(s) end menner as steled.

XX Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) end manner steled. 29a. Certifier (Check only one) within 2. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MARCH 14, 1999 address of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 es aner Jo

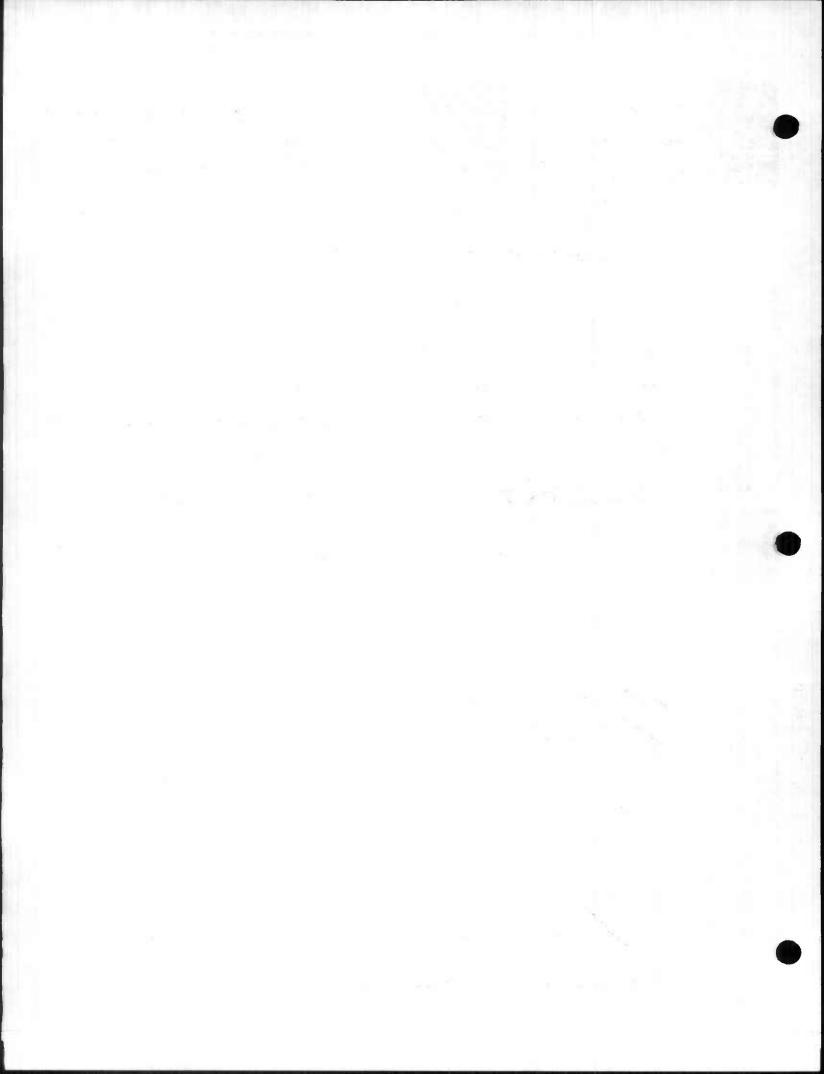
32 Registrer's Signature

State Registrar 31. Date tiled (Month, Day, Year)



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| | | | | | | | | rtificate | | Death | | Reg. No. | | 006.1 | | |
|---|--|----------------|--|---|---|---|---|---|------------------------|-------------------------------|---|--|---------------------------------------|---|--|--|
| | Physic | ian | 1. Decedant's Nan | na (First, Middle, La | | | | | 2. Data of De Month | eth Day | Yaar | 3. Tima of Death | | | | |
| | /Medi | | CHARLES EDWARD JONES | | | | | | | | | 16 1999 | | 2:15 AM | | |
| | Exami | | 4a. Facility Nama | (If not institution, given | e straet and num | b. City, Town, or | Location of Deat | | | | | | | | | |
| | | | Stella M | Maris | | | | | | Towson | | Baltimore | | | | |
| Г | Funeral | Г | 5. Social Security | Number 6. | Sax | 7. Aga (In yrs. | last birthday) | If Undar Months | 1 Yaar Days | If Undar 24 Hrs Hours Min. | | th Year | 9. Birthpla | ca (State or Foraign | | |
| | Director | | 216-01-2236 1M 2□F 90 Yrs. Months Days Hours Min. (Worth, Day, Year) Nov. 16, 19 | | | | | | | | | | Couring | Va. | | |
| | yland | | 10e. Stata | 10b. County | | 10c. Cit | ty, Town or Lo | cation | | | | | 100 | d. Insida City Limits | | |
| | Mar T | ţō | Md. | N/A | | Ba1 | ltimore | 9 | 1 Yes | | | | | | | |
| | Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, tra Medical Examinet must be notified at 200s. To Be Completed by Funeral Director | i e | 10e. Street and Nu | ımber | | | | 10f. Zip | Coda | | | 10g. Citizan of \ | Whet Country | y? | | |
| | | rai D | 218 N. C | Charles St | . Suite 400 212 | | | | | | | USA | | | | |
| 020 | | by | 11. Marital Stetus 1 Navar Married 2 Married 3 Widowed 4 Divorced | | 12. Was Deced Armed For 1 X Yes If Yas, Giva Yaar or Da | cas? 2 □ No | | . 13. Was Dacedent of Hispanic Origin? If Yas, specify Cuban, Mexican, Pue 1 □ Yas 2 ☒ No Specify: | | | specify Yes or No to Rican, atc.) | Specify | a - Amaricar ck, White, et Whit | c. | | |
| 2-0 | | ted | (Spe | 15. Decedant's E | ducation | | 16a. Dece | dent's Usual | Occup | ation | ulain a | 16b. Kind of B | usiness/Indu | stry | | |
| 2121 | | ompie | Elamantary/Sec | | Collaga (1- | 4or 5+) | 16a. Decedent's Usual Occupation (Giva kind of work dona during I lifa. DO NOT usa retired) Attorney | | | during most or wo. | rking | Law | Law | | | |
| D | Hyg H | | | (First, Middla, Last |) | | necoi | nej | T | 18. Mothar's Na | ma (First, Middle, | | na) | | | |
| an | od be | Be C | Edward | W. | | ones | | | | Margare | | | Dermot | ·+ | | |
| 2 | d Me | J. | | lame/Relationship (| | 01100 | 10h Maili | a Addroon | /Ctrant | and Number or Ri | | | | | | |
| Maryland | d 2 s th an | | | ard Berno | | nev | | | | | | | | | | |
| லி | 1 end 2 Haaith em 27 | | 20e. Mathod of Dis | | | - | Place of Dispo | | | s St. Su | Data Data | 20c. Location - | | | | |
| Baltimore, permit. Pages 1 er Depentment of Haa | Pages nent of ant: If its ury or o | | 1 Buriel 2 | ☐Cramation 3 ☐ 5 ☐Othar (Specil | | tata | ematary, crar w Cathe | natory or of | har plac | | 4/22/99 | Baltim | | | | |
| Balt | Depentit. Depentimport any inj | | 21. Signature of Funeral Service Learners 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | | | | | | | |
| - | | | 23a Part1 Enter | the disease or com | nlications that ca | used the deet | | | | | | | - 1 | Ingravimete | | |
| | Dhd-I | | shock, or has | the disaasa, or com art failura. List only | ona cause on aa | ch lina. | n. Do not am | ai tria mode | or dylli | | - | 11051, | le le | Approximata ntervel Batwaan Onset and Daath | | |
| | Physician /Medical | | Immediata Cause | /Final | | -sre | . بيندر ر م | ML | | 15 62/ | 1/5 | | | V FS | | |
| | Examiner | | disease or condition resulting in death) | n | a | | | | -/ | | | | | 7 | | |
| | | 70 | , | | | Due to (or as a consequence of): | | | | | | | | | | |
| 1/ | pe is | Examiner | | | b | | | | | | | | | | | |
| | rificete be axecuted ng physician and set the burial-transit | хап | Sequentially list co | onditions, | | Dua to (o | or as a consec | uence of): | | | | | | | | |
| 68760, | be a ician buria | | Sequantially list co if any, leading to ir causa. Entar Und Causa (Disease or | arlying r injury | C | | | | | | | | | | | |
| 8 | sete the | Medicai | that initiated avant rasulting in death) | S | | Due to (or as a consequance of): | | | | | | | | | | |
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| - | he a da | sic | Part il. Other signi | ficant conditions | entributing to dea | | | ndarlying ca | usa giv | an in Part I. | 23b. Did | 23b. Did tobacco use contribute to the cause of | | | | |
| О. | res thet tha da igned by the a be detached i | y Physician/ | 1151 | 129 12 fe | e 4 | alitar. | | | | | | Yee 2□ No | 3 Proba | bly 4凶Unknow | | |
| Records, | requir | Completed by | 14 | 47/6501 | 658115 | | | | | | | Vas en autopsy erformed? 24b. Wera eutopsy findin aveilable prior to complation of cause of death? | | | | |
| | The law ata hes page 2 | 5 | | | | | | | | | 10 | Yes 2 No | 101 | Yas 2□ No | | |
| VII | ician: Th certificata rector, pag | Be (| 25. Was casa refe | rred to medical | | | | | | 28. Placa of Da | ath (Check only o | na) | 1 | | | |
| > | \$ 00 | To I | axaminer? 1 ☐ Yes 2 | No | Hospital: 1 ☐ In | patient 2 | ER/Outpatier | t 3 DO | A Oth | er: XXNursing H | ioma 5□ Rasio | dance 6 Oth | er (Specify) | | | |
| on of | ding Ph th. After thi funeral | | 27. Mannar of Dea 1 ☑ Natural 2 ☐ Accident | th 5 Pending Invastigation | | Injury Day Year) | 28b. Tima of Injury | M 28 | Bc. Injun | | | now Injury occur | | | | |
| Division | f or Attanding efter death. Director: After d in by the fune | Certification: | 3 Suicide 4 Homicide | 6 Could not b datamined | e 28a. Place o | of Injury - At ho g, etc. <i>(Specif</i>) | oma, farm, str | aat, factory, | office | N. 10 | 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) | | | | | |
| | To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b | | 29a. Cartifier | 1 Cartifying Ph | valcian: To the h | est of my know | wledna daatt | occurred a | t the tim | a data and place | and due to the | nauca(c) and ma | innar as stat | ted | | |
| | n 24 h | edicai | (Check only one) | 2 Medical Exam | ninar: On the bas and manna | is of axaminat | tion and/or in | astigation, | In my op | pinion, daath occu | rred at tha tima, | data and place, | and dua to th | na causa(s) | | |
| | With Com | Σ | 29b. Signetura and | till of certifier | // | | | 29c. | License | number | | 29d. Dete signe | | | | |
| | | | / | July Ha | redt | w | > | | 1 | D 15504 | | 4.16 | . 5 | 7 | | |
| 1 | OXI | | 30. Nama and adde | ress of person who | completed cauca | of death /Item | 23a\ /Tune | Print) | | | | | | | | |
| - 1 | U" | | | Nakhuda, | | | | | בת | m÷ | ndiam tes | 22002 | | | | |
| | Sta | ** | | | | 300 Dul gj e trar's Signa | | arrey | Ka | TIMOI | nium, Md | 21093 | | | | |
| | Sta Registr | ar | 31. Date filed (Mon | APR 21 | 1999 | ineres | 19 | . 1 | oork | 21 | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month JAMES APRIL 1999 15. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hours Min. 8. Data of Birth (Month, Day, Year) HOSPITA BALTIMORE hurch Birthplace (State or Foreigns Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 18M 20 F Months Days 245-34-7686 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location BALTIMOre 1 Yes 2 No mid 10g. Citizen of What Country? 10a. Street and Number BOND 1515 21213 12. Was Decedent Ever in U.S. Armed Forces? 1 EYes 2 □ No If Yes, Give Year or Dates:/94/5-/44/5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2☑No Specify: African American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert JOYCE Caroline Joyce 19a. Informant's Name/Raletionship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. BOND Street BACIIMOU IMD. 2/2/3 GLadys Joyce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 Cremation 3 Removal from State 4-22-99 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) ForesT 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Albert P. Wylie 638 N. Gilmor Street BALTIMON, MD. 21217 23a. Part 1. Enter the disease, or pomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last CARCINOMA Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 2 No 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 death with

"natural", or Nems 23s

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Hem 27 is marked other than "natural" other than instural.

the Medical Examiner must be notified at

Funeral Director

by

Completed

Be

the Maryland

physician and the burial-transit

Examiner Physician/Medical py Be Completed Medical Certification: To

The lew requires that the death certificate be executed Records, P.O. Box 68760 signed by the atte Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

AND 10

State Registrar 31. Date filed (Month, Day, Year) 2 0 1999

27. Manner of Death

1 A Natural
2 Accident

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 ☐ Could not be

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

29c. License number

1 Yes 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

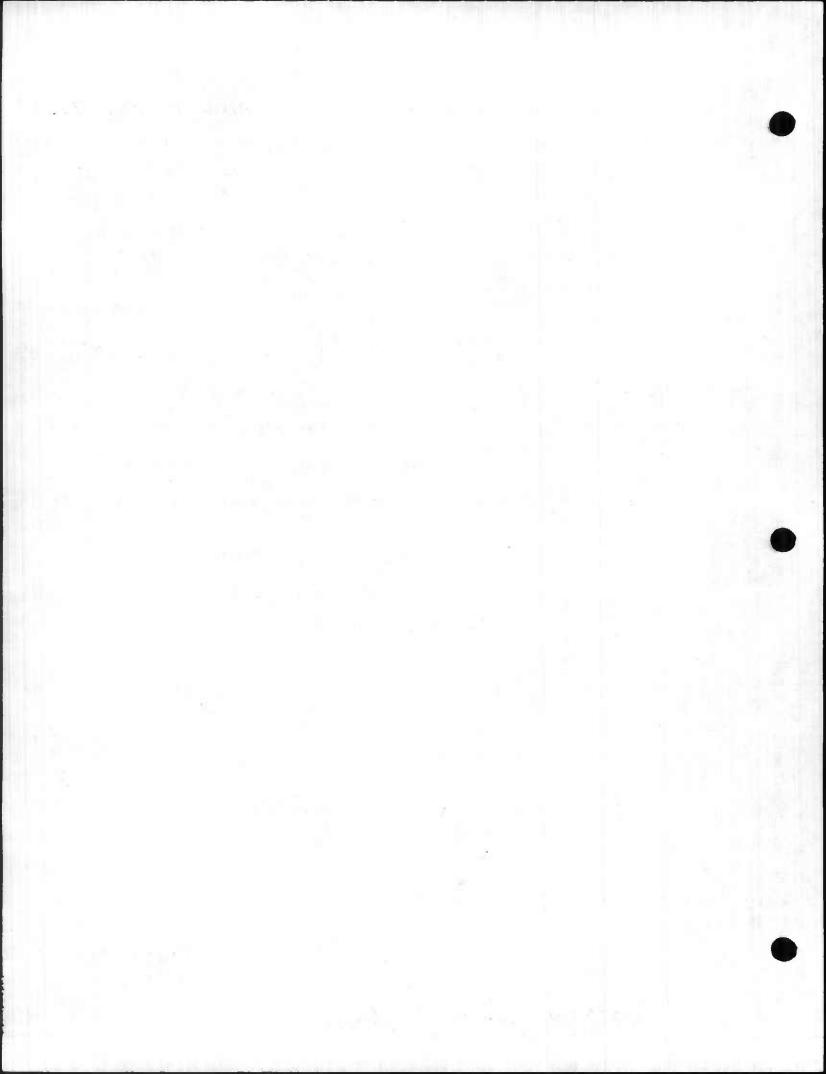
28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23s) (Type, Print) UNIL

100 N. Broadway 32, Registrar's Signature

28b. Time of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo

| | | | | iai yiai iu | | ificate of | Death | | Reg. No. | | 3023 | | | | |
|--|---|--|--|---|---------------------------------|--|--|--|-----------------------------------|------------------------------|---|--|--|--|--|
| Physic | an | Decedent's Nama (First, Middle, Li | ast) | | | | 2. Data of Dea Month | th Day | Year | 3. Time of Death | | | | | |
| /Medi | | JOSEPH LEO | KERRIGA | N SR | | | | APRIL | | 1999 | 11:55 PM | | | | |
| Exami | | 4a. Fecility Neme (If not Institution, gir | | | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | | | | |
| | | Saint Joseph | Medical | Cent | er | | Tows | n | E | }alti | more | | | | |
| Funeral Director | | | | ge (In yrs. las 57 | st birthdey) Yrs. | If Under 1 Yaer Months Days | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day Feb. 17 | 7, Year) 7-32 | 9. Birthple Count Mary | ece (Stata or Foraign lry) l and | | | | |
| anyland show | | 10a. Stata 10b. County | | | Town or Loca | | | | | 10 | Od. fnside City Limits | | | | |
| W T | cto | Maryland N/A | | Ba | 1timor | е | | | | | 1 Yas 2□No | | | | |
| ith with the Maryla 23a or 28a-f shov ust be notified at | Funeral Director | 10e. Street and Number 10f. Zip Coda 10g. Citizan 802 W. 37th Street 21211 US | | | | | | | | | ry? | | | | |
| eath | era | 11. Meritef Stetus | 12. Was Decedent | Ever in II S | 13 W | | | pacify Vac or No. | | e - America | an Indian | | | | |
| filed within 72 hours after death with the Maryland Hypiene. Ither than "natural", or items 23s or 28s-f show and, the Medical Examiner must be notified at | by Fun | 1 Nevar Married XX Married 3 Widowed 4 Divorced | Armed Forces | Armed Forcas? tt Yas, specify Cuban, Maxican, Puèrto Rical 1 □ Yes 2 □ No 1 □ Yes 2 □ No Specify: | | | | | | ck, Whita, e | etc. | | | | |
| of 2 should be filed within 72 hours of the and Mental Hyglene. 7 Is marked other than "natural", or traumatic event, the Medical Exam. | Completed | 15. Decedant's E (Specify only highast gr | ada complatad) | mplatad) (Giva kInd of work dona during most of working | | | | | | usinass/Indi | ustry | | | | |
| filed within Hygiene. other then | E | Elementary/Secondary (0-12) | College (1-4or | 5+) | | al Assi: | | | Funeral Service | | | | | | |
| The Tree | Ö | 17. Fether's Neme (First, Middle, Last |) | | | | 18. Mothar's Nam | a (First, Middla, | | _ | , , , , | | | | |
| should be nd Mental marked o | To Be | Martin Kerrigan | | | | | Irene | Patrick | | | | | | | |
| | | 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Z 37th Street, Baltimore, Marylan | | | | | | | | | | | | | |
| - 구 등 등 | | 20a. Mathod of Disposition | | non- | ce of Disposit | ion (Nama of tory or other ple | cel | Deta | 20c. Location - | City or Tov | wn, Stata | | | | |
| Pages 1 and ment of Healt ant: If Nem 27 ury or other I | | 1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control |]Ramovel trom Stata fy) | | | | | 4/22/99 | Cockes | ville | . Marvland | | | | |
| permit. Pages 1 an Department of Heal Important: If Nem 2 any Injury or other | | 21. Signeture of Funeral Sarvice Licensee 22. Nama and Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 212 | | | | | | | | | | | | | |
| Dhysiolan | | 23a. Part 1. Enter the issuese, or complications that caused the death. Do not enter the mode of dying, such as cardled or respiretory errest, interval Between Cheet and Death | | | | | | | | | | | | | |
| Physician /Medical | Immediata Cause (Final disease or condition REFRACTORY CONGESTIVE HEART FAILURE | | | | | | | | | | | | | | |
| Examiner | 16 | rasulting in daath) Dua to (or as a consequanca ot): | | | | | | | | | | | | | |
| uted I Insit | mine | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseasa or Injury thet initiated events resulting in death) Last Due to (or as e consequence of): C. Due to (or es e consequence of): C. Due to (or es e consequence of): d. | | | | | | | | | | | | | |
| the death certificate be executed by the attending physicien and iched for use as the burial-transit | al Exa | | | | | | | | | | | | | | |
| 2 0 4 | - | | | | | | | | | | | | | | |
| death certification attending of for use a | iclan | Part li. Other signiffcant conditions of | contribution to don't b | and not records | ion in the read | a de da a casa a de | on in Don't | not Did a | | -4-15-4-4- | the entire of distance | | | | |
| hat the death cer od by the attendir detached for use | Physiclan/M | raitii. Other significant conditions (| contributing to death s | out not rasuiti | ing in tha und | anying cause giv | | es 2 🕱 No | | the cause of death? | | | | | |
| requiras t been signe should be | Completed by | | | | | | | 24a. Was a perfor | | com | ra autopsy findings ilable prior to npletion ot causa leath? | | | | |
| The law ata has page 2 | mo | | | | | | | 1 🗆 Y | as 2 No | 10 | Yes 2 No | | | | |
| sician: The certificata rector, pag | BeC | 25. Was casa retarred to medical | | | | | 26. Placa of Dea | | | | | | | | |
| Physician: this certific ral director, | ToE | axaminer? 1 Yas 2 No | Hospital: | ent 2 EF | R/Outpatlent | 3 DOA Oth | 00 | oma 5 Rasid | | er (Specify |) | | | | |
| D 1 | ation: | 27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigatio | 28a. Data ot Inju (Month, Da | Jry 2 | 8b. Tima of tnjury | 28c. Injur Wor | | 28d. Dascribe h | | | | | | | |
| To the Hospital or Attending within 24 hours after death of To the Funeral Director: After completely filled in by the fune | Certification: | 3 Suicide 6 Could not be datermined | Zoa. Place of in | ury - At hom c. (Specify) | treet and Numb n, Stata) | er or Rural | Route Number, | | | | | | | | |
| Hospitu 24 hours Funera letely fille | edical (| 29a. Cartifiar (Check only one) 1 Certifying Pt | ysician: To the best niner: On the basis o and menner st | t axamination | edga, daath o n and/or invas | ccurred at tha tir stigation, in my o | ma, date and piece, pinion, daath occur | and dua to tha c red at tha tima, c | ausa(s) and ma lata and place, | unner as sta and dua to | ated. the causa(s) | | | | |
| Within To the | Me | 29b. Signeture end title of certifiar | | | | 29c. Licens | e number | 2 | 29d. Deta signe | d (Month, E | Day, Year) | | | | |
| | | Realizet | Durge | -,/ | n.D. | D16 | 492 | | iquit | 219 | 1999 | | | | |
| | | 30. Nama and address of person who | complated dause of c | leath (Item 2 | 3a) (Type, Pr | int) | | | V | | | | | | |
| | | BEATRIZ DIZON, | | | | RIVE, | TOWSON, | MARYLA | ND 212 | 04 | | | | | |
| Sta Registr | | 31. Data tiled (Month, Day, Year) | 32. Registr | ar's Signatur | | . ppo | rekel | | | | | | | | |

and the product of the first of the second s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer Month 17, 1999 ath 4c. County of Death JANE KELLY April 7:40 PM 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death Mariner Health Center of Forest Hill Forest Hill Harford Birthplaca (Stete or Foreign Country) If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Data of Birth (Month, Dey, Yeer) 1 □ M 2 1 F Days Months Hours Md. 212-12-2019 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 K No Harford Fallston 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2425 Munford Dr. 21047 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Marriad 2 Married Specify: White 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Home maker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) E. DeVan John Sara Jane Mullan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mr. John Kelly/son 2425 Munford Rd. Fallston, Md. 21047 20b. Place of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4/21/99 Pikesville, Md. 21. Segrature of Funeral Service Line 22. Name and Address of Feclity Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on eech line. Approximate Interval Between Onsat and Deeth Immadiate Ceuse (Final disaasa or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of ceusa of deeth? 24a. Was an autopsy 1 Yas 2 No 2 No 1 Yas

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland hart of Health and Mental Hygiene. Intil if item 27 is marked other than "natural", or items 23e or 23e-f show may or other treumatic event, the Medical Exterior or mostle or nother all you could be a some the Medical Exterior or nother death or nother than the mostle or nother all or nother than the mostle or nother all or nother

Baltimore, Maryland 21215-0020

MARY

Md.

Examine physician end s the buriel-transit Physician/Medicai þ Completed Be 2 Certification:

ettending pl signed by the e been si his certificate has but director, page 2 sf or Attending Physician: this funeral efter deeth Director: To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in by

The lew requires that the death certificate be execu

Division of Vital Records, P.O. Box 68760,

State

Registrar

Medical

25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 1 Naturai 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licensa number

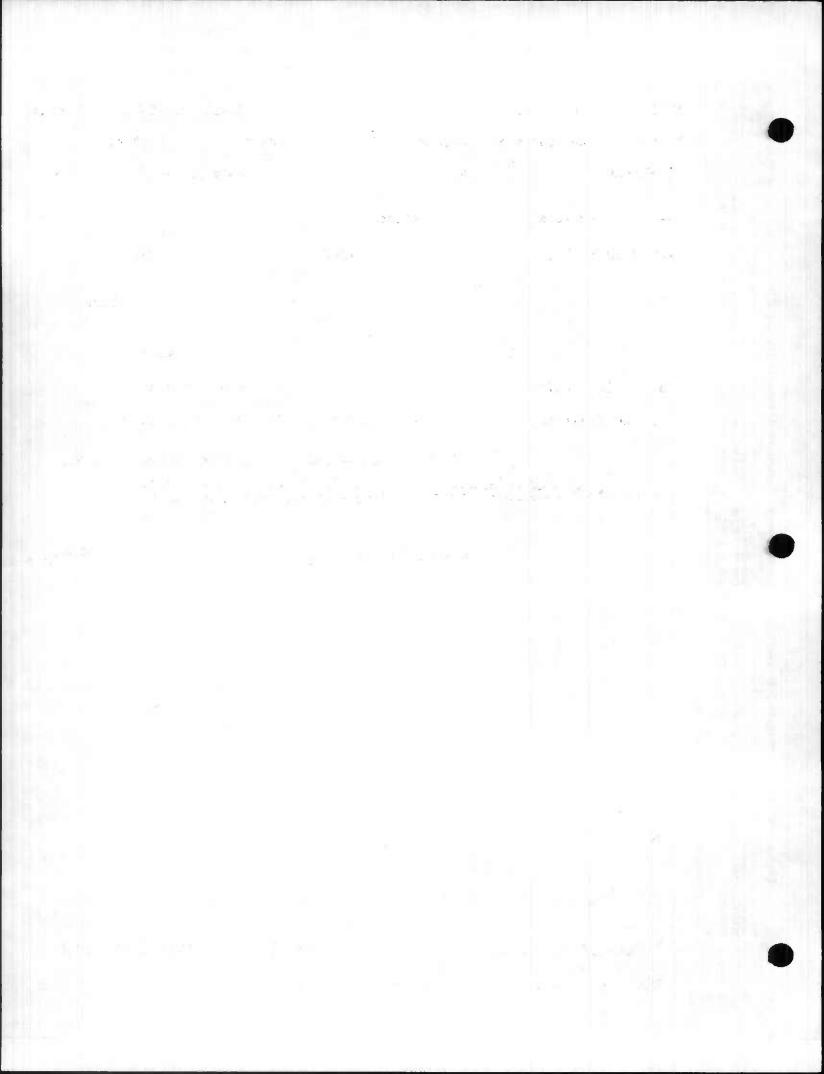
D3552

april

30. Name and eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

Do 615 W. 2.

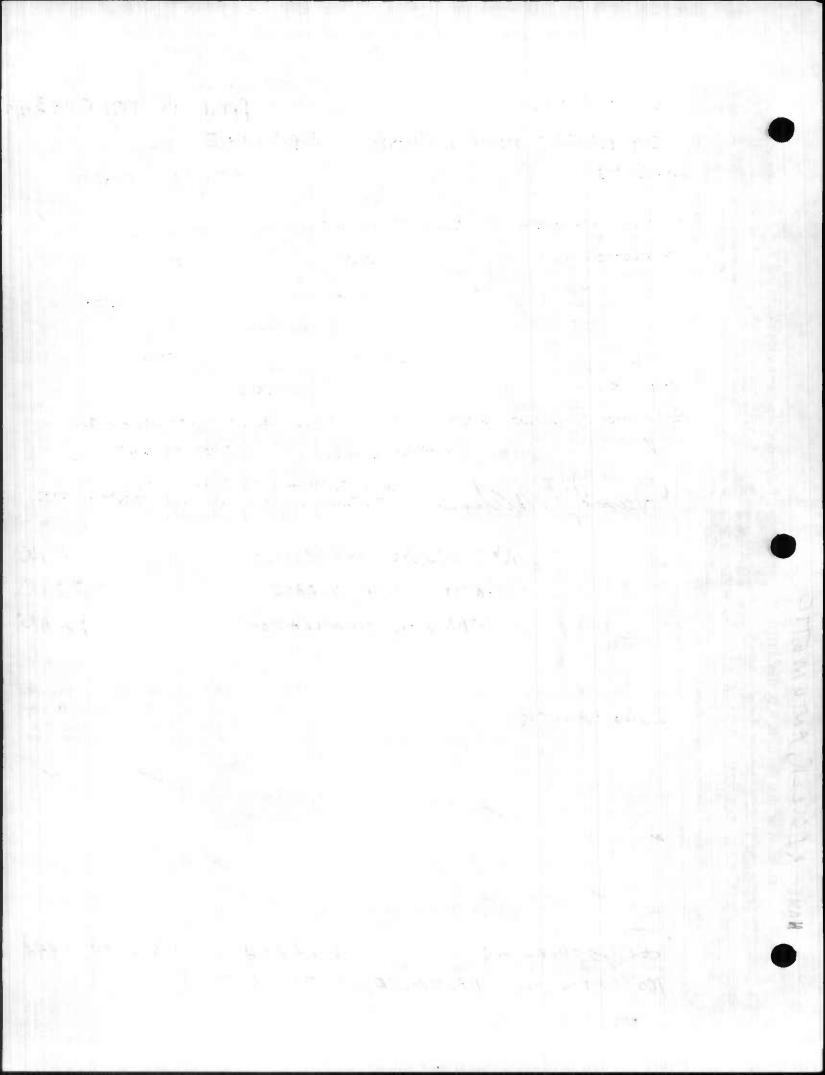
31. Date filed (Month, Dey, Yeer) APR 2 1 1999 32. Begistrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Antoinette M. Kessler 034 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or L Examiner BALTIMORE HEALTH CARE ST AGNES If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dafe of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F Yrs. 220-20-3973 Director 09/25/1927 Maryland Usual Residenca of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits r 28a-f ahow 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville Manor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "netural", or items 23s or ad cal Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Wed 5908 Carroll St. 21207 Funeral Was Dacedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Bace - American Indien Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifta. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Paul Andreone Rose Papa 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Christopher J. Kessler/Husband 5908 Carroll St. Cantonsville Manor, MD 21207 20b. Place of Disposition (Nama of Date 20c. Location - City or Town, Stete 20a. Methed of Disposition woodlawn cemetery 1 DBurial 2 Cramation 3 Ramoval from Stata 4/22/99 Maryland 4 ☐ Donafion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Pert I. Enter the disease of complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Int only one cause on each line. Approximate Interval Betwaen Onset and Death Physician /Medical Immediata Ceusa (Final a. MVOCARDIAL INFARCTION

Due to (or as a consequence of): disaasa or condition resulting in daath) Examiner Physician/Medical Examiner CORONARY ARTERN DISEASE

Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that initiated avants resulting in deeth) Lest VENTRICULAR AME KESSLER, ANTOINETT FIBRILLATION Part ff. Other *fgnificant condition* contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No LUNG CANCES 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 9 No 1 Yas 2 DNO 25. Was cesa refarred to medical axaminar? 26. Placa of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 ☑ Inpatiant 2 ☐ ER/Outpatienf 3 ☐ DOA 1 □ Yas 2 □ No 28e. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? 5 Panding Investigation 1 A Natural 1 ☐ Yas 2 ☐ No 2 Accidant after deat Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homleida 8 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, data end piece, end due to the ceuse(s) and menner as steted Medical 2 Medical Examiner: On the basis of examination and/or investigeflon, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. (Check only one) 2 Fo the 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifia askam no 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) CATON BALTIMORE 31. Data filed (Month, Day, Yaar) 32 Ragistrar's Signature State Registrar 1000



Please Type or Print in Biack indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Charles Brunier Knode Jr. 6:50 AM April 18, 1999 /Medical 4a Facility Name (If not institution, give street end number) 4h City Town, or Location of Death 4c. County of Daath Examiner 3912 Colchester Road Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 46 215-50-5271 Yrs July 15, 1952 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? ie marked other than "natural", or flems 23a or 28a-f show traumstic event, the Medical Examiner must be notified at MD N/A 1⊠ Yes 2 No Director Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3912 Colchester Road 21229 U.S.A. death y Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 25 Married Baitimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If fem 27 is marked other than any Injury or other traumatic event, the language and injury or other traumatic event, the language. Elemantary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Retail 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Brunier Knode Sr. Thelma Mae Handler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marie D. Knode/Wife 3912 Colchester Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Meadow Ridge Cemetery 4/22/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc 6415 Belair Road Baltimore, Maryland 21206 on final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this on each line. Approximate tnterval Between Onset and Death sease, or complication Physician /Medical Immediate Cause (Fina OVVE disease or condition rasulting in death) Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Dua to (or as e consequence of): P.O. Box 68760, Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. by The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen : page 2 : 1 Yes 2000 1 ☐ Yes 2 ☐ No certificate Division of Vitai oepital or Attending Physician: Thours after death.

Juneral Director: After this certification by the funeral director, E Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Datural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida in 24 hour.
The Funeral Direction of the funer 29a, Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. drie)

State Registrar 29b. Signature and title of

DHMH 16 Rev 6/95

Faederick

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

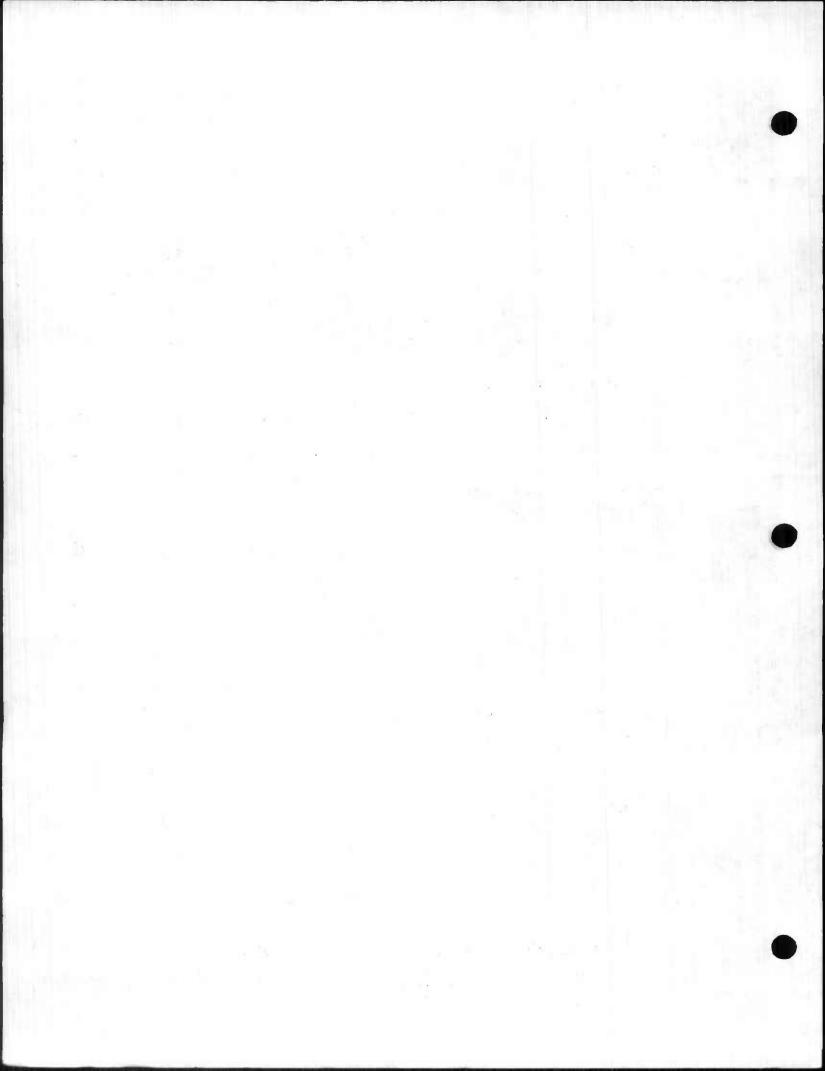
Millermo

APR 21

29c. License number

Rd. Suite 110, Catorsville,

29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 3. Time of Death 2. Deta of Death Month Day Yaar Physician Jack Robert Licata, Sr. 19, April 1999 8:09 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore Co. If Under 1 Year | If Under 24 Hrs. | Birthplace (Steta or Foreign Country) 5. Sociel Security Number 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1X M 2 F 157-22-5917 80 February 02,1919 Trapani, Sicily Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Steta 10b. County r 28a-f show notified at the Marvia 1 Yes 2 No Maryland Baltimore Co. Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 極 8 munt be Berns 23a 6838 Queens Ferry Road 21239-1225 Funeral United States of America 12 Was Decedent Ever in U.S. 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian Bleck, White, etc. 11. Merital Status Armed Forces?

1 X Yas 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 Married "natural", or Maryland 21215-0020 1 Yes 2 No Specify: W.W.II Specify: White å 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene Unknown Unknown Food Broker Food Distributor is marked other 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Be should be and Mental To Colerogo Licata Rose Maggio 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) important: if hen 27 is any injury or Mrs. Mary Grace(Nee Alberti)Licata(Wife) 6838 Queens Ferry Road Baltimore, Maryland 21239-1225 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Dulaney Valley Memorial Gardens 4/21/1999 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Fecility Ruck Towson Funeral Home, Inc. 21. Signeture of Fungral Service Licensee Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 Inter the deelse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximate tntervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) Colon Cancer disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or injury that battled engles are or injury) Due to (or as a consequence of): Box 68760. 8 Physician/Medical that initiated events resulting in death) Lest Due to (or es a consequence of) 88 950 ò Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. eun á 1 Yee 2 No 3 Probably W Unknown signed b þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu hes page 2 1 Yes 2 X No 1 ☐ Yas 2 ☐ No certificate Division of Vital director. 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Cother (Specify) Hospice 2 1 ☐ Yes 2X No this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27 Menner of Death Certification: 28b. Time of 28c. Injury at Work? After or Attending 1 X Netural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifie (Check only one) To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signeture, and title of certifier 29c. License number 4/20/99 D43725 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093 31. Date filed (Month, Dey, Year) APR 2 32. Registrer's Signature

DHMH 16 Rev 6/95

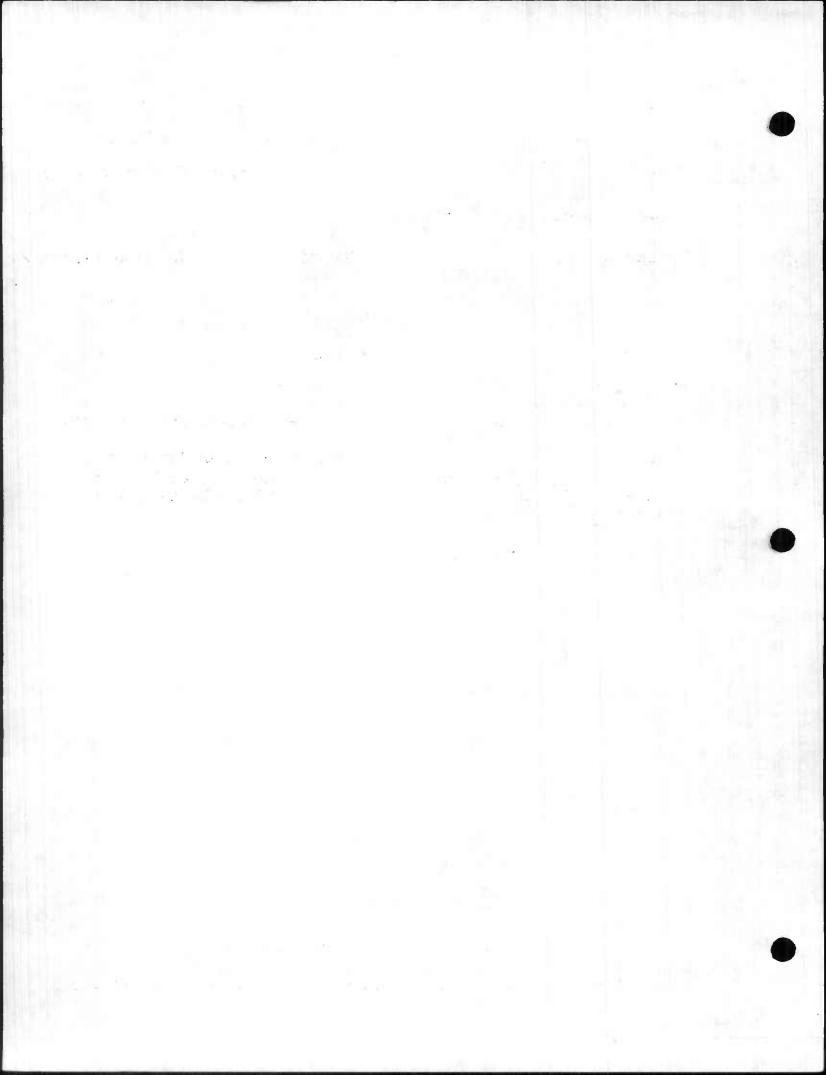
State

Registrar

pril 19, 1999

Jack Licata

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year **Physician** Catherine M. Locklear 11:00 PM April, 18 1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford 2543 Johnson Mill Road Forest Hill # Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Months | Days | Hours | Min. | (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2K F 58 Maryland Director 217-38-0222 12/20/1940 Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at the Marvie 1 Yes 2 No Directo Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 USA 2543 Johnson Mill Road than "natural", or liams 23a the Medical Examiner must b 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian. 11 Merital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hisd within 7 Hygiene. Other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if them 27 is marked other th any injury or other free Homemaker Domestic 12th 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) 86 Catherine Panzer Joseph Ratajczak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 803 Sidehill Dr. Bel Air, Maryland 21015 Kathleen Weber/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4/23/99 Maryland Stanislaus Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Get only one cause on each line. Baltimore, Maryland 401 S. Chester St. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARCINOMA OF LUNG 3 YEARS Examiner Due to (or as a consequence ot): Examiner burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760. certificate be Physician/Medical the Due to (or as e consequence of): P.O. Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? eup 1 Tea 2 No 3 Probably 4 Unknown CARCINOMA OF MOUTH Records. by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE SBL 1□ Yes 28 No certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home StartesIdence 6 Other (Specify) Certification: To 1 Yes 3 No this 28a. Date of fnjury (Month, Dey Year) Director: After the 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? papital or Attanding hours after death. 1. Naturef 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier D08096 A Novalionsti mo. APRIL 19, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Particular AROWSKI MD (25) 125 N, MAIN ST BOAR, MO 210/P ANOWAKOWSKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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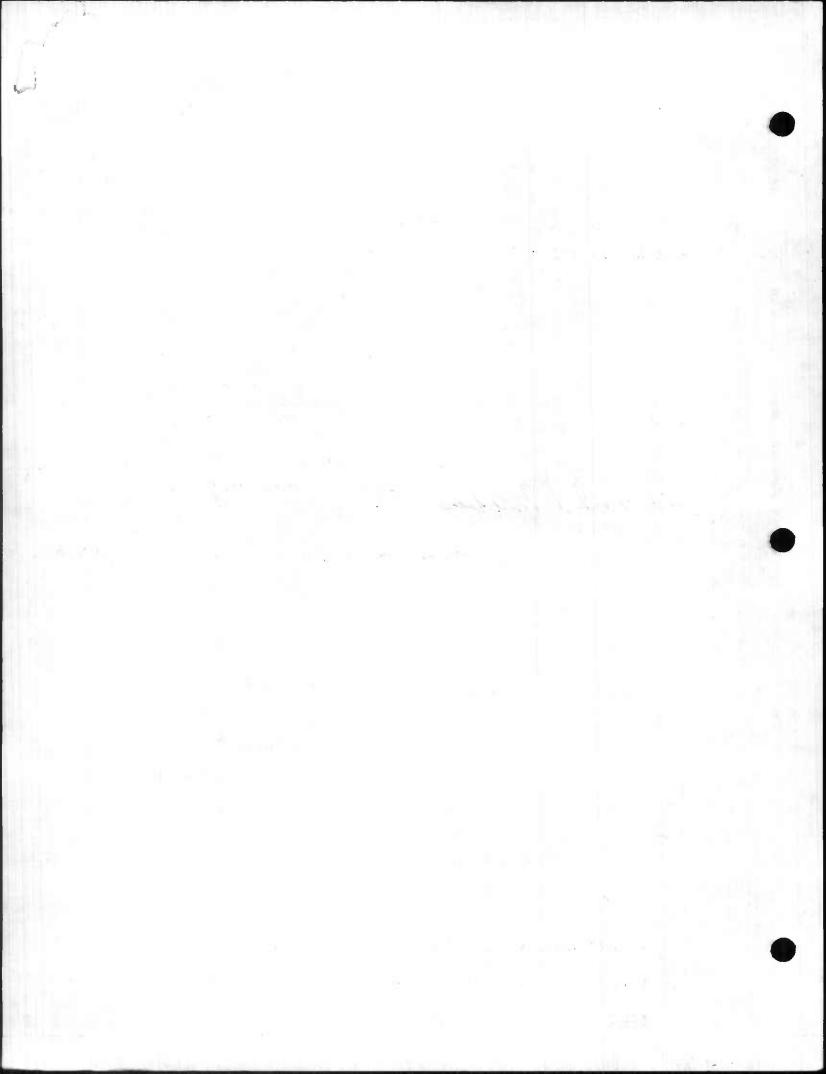
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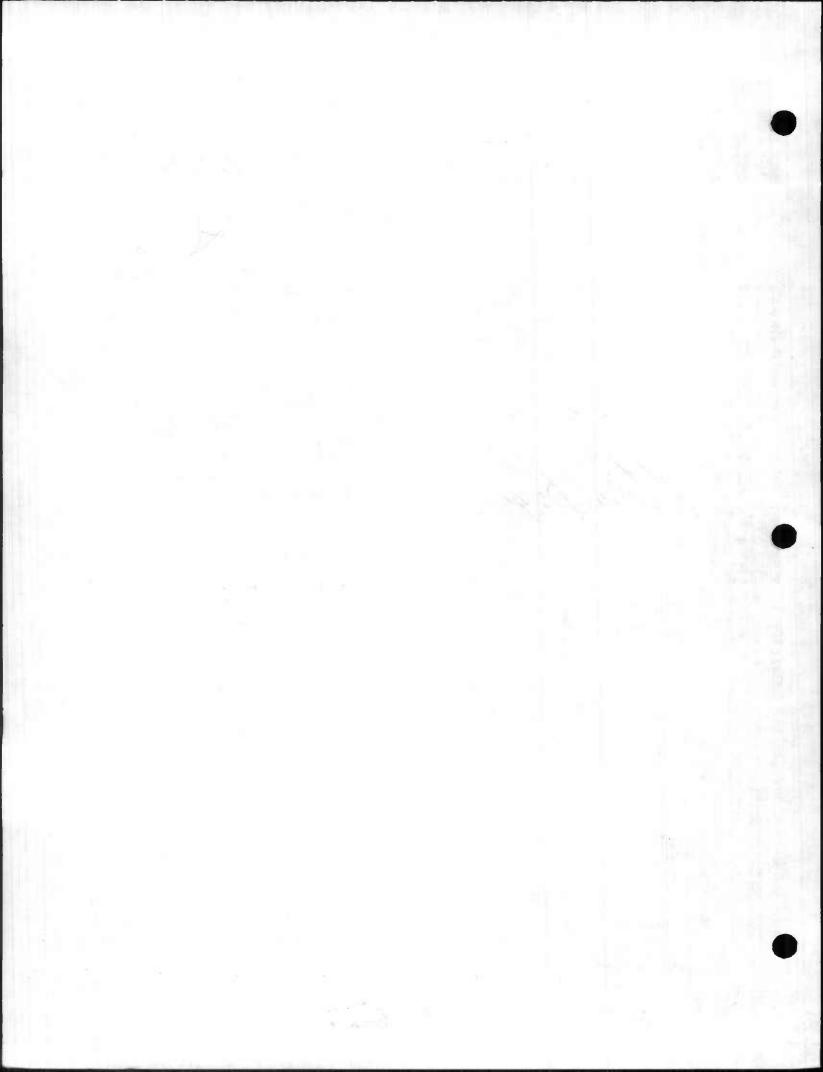
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|--|---|--|---|---|--|--|----------------------------------|--------------------------------|---|---------------------------|--|--|--|
| Physician /Medica | - | Nama (First, Midd | lie, Last) LTON | | I | AVENSTE | IN | 2. Date of D Month APRIL | Day 1999 | Year | Time of Death 2:30 AM | | |
| Examine | 4a Facility Nan | | n, give street end n | m, or Location of Des IORE | cation of Death 4c. County of Death N/A | | | | | | | | |
| Funeral Director | | 3-5209 | 6. Sex 1 1 M 2 □ F | 7. Aga (In yr 90 | rs. last birthday) Yrs. | Months Day | | 4 Hrs. 8. Date of 8 (Month, D | irth Nay, Year) 18, 1908 | 9. Birthplaca Country) | (State or Foreign VA | | |
| pug * | Usuat Resident | 10b. County | , | 10c. (| City, Town or Lo | cation | | | | 10d. Inside Cit | | | |
| Aarylar I ahow | | | LTIMORE | | | BALTIMOR | E. | | | | Yes 250 No | | |
| with the Mar | | 1 Number | H - APT. | 7 | | 10f. Zip Code | | 08 | 10g. Citizen of What Country? U.S.A. | | | | |
| 5-UUZU 72 hours after death with the Maryland natural', or ferns 23a or 28a-f show sited Examine must be morthed at | 11. Marital Stat | lus Married 2X Mar | 12. Was De Armed F ried 1 Yes | cedent Ever in Forces? 2 2 No Give | | Was Decedent of If Yes, specify Cu | Hispanic Origi ban, Mexican, | o- 14. Rac | e - American Inck, Whita, atc. | WHITE | | | |
| 72 hours natural, align Eng | | ed 4 Divorced | Year or | Datas: | 16a Dasa | dent's Usual Occ | unation | | 16h Kind of B | usiness/Industr | | | |
| d within giena. | Elamentary/ | Specify only higher Secondary (0-12) | st grede completed | f) (1-4or 5+) | (Give | kind of work don DO NOT use retii | e durina most | | FURNITURE STORE | | | | |
| Maryland 212 d 2 should be filed within and Mental Hygiena. 7 la marked other than traumatic event, the traumatic avent, the traumatic avent ave | 17. Fathar's Na | ime (First, Middle, IS | Last) ADOR | | LAVE | NSTEIN | 18. Mothar | 's Name (First, Middle MARY | GANN | | | | |
| | | 's Name/Relation | | or Rural Route Num | ber, City or Town, | State, Zip Cod | le) | | | | | | |
| a a a a a a a a a a a a a a a a a a a | | AVENSTEI | N / WIFE | | | | TH #7 - | - BALTIMOR | - | | | | |
| Baltimore, permit. Pages 1 ar Department of Hear Important: If New? any Information of the articles of the art | | | 3 □Removal fun Specify) | Sata | cemetery, cre- | sition (Name of metory or other p V CHIZUK | | Date 4/18/99 | 20c. Location - BALTII | MORE, M | | | |
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| - 40364 | MAR | wall, | Muse | r | | | | WN ROAD - | | | | | |
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| Physician / /Medical / Examiner / | Immediate Car disaase or con resulting to dea | dition | a | | | | HEAR | F FAIL | URE | 3 | DAYS. | | |
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| | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHCINDAA OF THE BLADIEN. 23b. Did tobacco use 1 Yea 2 N CHLONIC OBYNCTIVE WNG SIS GASE 24a. Wes an autopsy performed? | | | | | | | | | o 3 Probably 45 Unknown | | | |
| 2 2 8 B | | CHA | Lonic (| OBSM | UCTIVE | WNG | 5150 | 545 E 24a. We per | s an autopsy formed? | availab | outopsy findings ble prior to ation of cause h? | | |
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| vital The cartificata rector, pag | | refarred to medica | | | | | | of Daath (Check only | one) | | | | |
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| UNISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fun | 29a. Certifier (Check only one) | 1 Certifying 2 Medical | Examiner: On the | ne best of my ki basis of exami innar stated. | nowledge, deat nation and/or in | n occurred at the vestigation, in my | time, date and opinion, deeth | place, end dua to the | e cause(s) and me e, date and place, | end due to the | l. cause(s) | | |
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| State Registrar | | Month, Dey, Year, | 39 Ber | Registrer's Sig | | 1 | | | | | | | |
| DHMH 16 Ray 6/95 | A | N N U 13; | 33 / | | 1 | yours! | | | | | | | |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth LIPMAN IRVIN JONAS APRIL 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F 214-16-8729 FEB.11,1922 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2♥ No MD BALTIMORE OWINGS MILLS 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 997 JOSHUA TREE COURT 21117 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES PUBLISHING 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) MEYER LIPMAN BERNSTEIN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANA LIPMAN / WIFE 997 JOSHUA TREE COURT - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Removal from State BALTIMORE HEBREW CEMETERY 4/18/99 REISTERSTOWN, MD Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 pase, of compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, re. List only one cause on each line. Approximeta Intarval Between Onset and Death BOWEL INFARCTION Immediata Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case refarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

Examiner Examiner attending physicien end for use as the burisi-transit or Attending Physician; The law requires that the deeth certificate be executed 5x 68760. Division of Vital Records, P.O. After this a 24 hours after deeth.

Funerel Director: After the function of the function

Physician

/Medical

Examiner

Funeral

Director

x 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If New 27 is marked other than "natural", or Nems 23s or any Injury or other traumfall event, the Medical Examine must be an obse-

Physician

/Medical

Baitimore, Maryland 21215-0020

Director

Funeral

þ

Completed

8

Physician/Medical þ Completed 8 Certification: To

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 ☐ Suicide 4 Homicide

(Check only one)

29a, Certifie

6 ☐ Could not be

investigation

28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to tha cause(s) and manner stated.

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

29c. License number 37 333

29d. Date signed (Month, Dey, Year) APRIL 15, 1985

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NHC, BALTO. MD 21173 31. Date filed (Month, Day, Year)

State Registrar

Medical

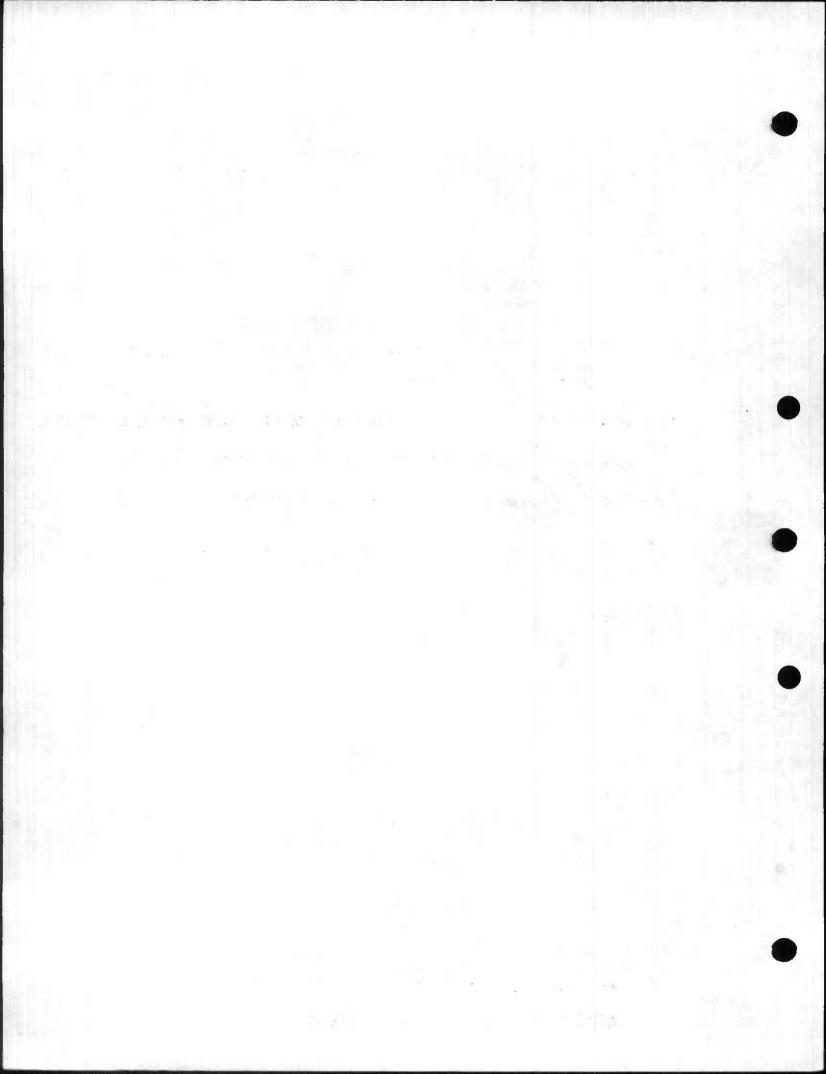
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32. Registrar's Signature

DHMH 16 Rev 6/95

Hospital

To the Hosp within 24 hou To the Fune completely fi



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WYVETREA

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State of Maryland / Department of Health and Mental Hygiene

| ertificate of Death | Reg. No. | 1303 |
|----------------------------|-------------------|------|
| artificial of Ficaltif and | I Wellai Hygielle | 1000 |

111 Penn Street, Baltimore, Maryland 21201

| Physician | |
|-----------|--|
| /Medical | |
| Examiner | |

Funeral Director

Baltimore, Maryland 21215-0020 **Physician**

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director,

| 1. Dec | edant's Nam | a (First, Mic | idia, Las | t) | | | | | | | | | 2. Data of Month | Death | Day | Yaar | 3. Tima of | Death |
|---------------------------|--|----------------------------------|--|------------------------------------|----------------|------------|--------------------|-------------------|--------------------------|------------------------|---------------------------|------------------------|---|-------------------|----------------|----------------------|--|-----------|
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| | | | | street and nu | ım <i>ber)</i> | | | | | | 4b. City, T | own, or | Location of D | eeth | 4c. County | of Deeth | | |
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| unk | al Security N | | 6. Se | ox □M 2∏(F | 7. Aga | (In yrs. I | | rs. | Months | | | | | Day. | 1966 | Cou | place (Stata ontry) | or Horaig |
| 10a. S | Rasidence of tata | 10b. Cour | ity | | | 10c. City | , Town | or Loc | ation | | | | | | | | 10d. Insida C | Ity Limit |
| Max | rv1 am d | | | | | D = 1 | | | | | | | | | | | 1 ♥ Yas | |
| - | yland treet and Nur | mher | | | | bal | time | ore | 10f, Zip | n Coda | | | | 10 | What Cou | intry? | | |
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| 10 | Navar Marri Widowed | ied 2□ M | arried | Armed F 1 Yas If Yas, G Yaar or I | orcas? 2 N | 0 | | 1 | Yas, special Yas nknov | 2□ No | | | Specify Yas or to Rican, atc. | | | ck, Whita | | |
| | | 15. Deced | | | | | 16a. | Deced | ant's Usua | al Occu | pation | | | 1 | 6b. Kind of B | usinass/ir | ndustry | 147 |
| Flor | (Specinentery/Seco | | | da complated, College | | | | lifa. D | O NOT u | ork dona isa ratire | i <i>during</i> mo ed) | St of Wo | orking | | | | | |
| | nown | riodily (0-12 | | nknown | (1-401-51 | 1 | | un | knowi | n | | | | | unkn | own | | |
| 17. Fa | thar's Nama | (First, Middl | a, Last) | | | | | | | | 18. Moth | nar's Na | ma (First, Mic | idia, M | aidan Suman | na) | | |
| unk | nown | | | | | | | | | | unk | cnow | n | | | | | |
| 19a. lr | ntormant's Ne | eme/Raiatio | nship (7 | ype, Print) | | | 19b. | Mellin | g Address | s (Straa | t and Numi | ber or R | lural Routa Nu | ımber, | City or Town, | Stata, Zi | p Coda) | |
| unk | nown | | | | | | | un | knowi | n | | | | | | | | |
| 11 | 20a. Method ot Disposition 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Mothar (Specify) in state | | | | | | lace of emetery | Dispos /, crem | ition (Nar atory or o | ma of othar pla | aca) | Data | Data 20c. Location | | | own, Stata | | |
| | gnature of Fu | | | | | | _ | 22 | Nama ar | nd Addr | ass of Faci | lity | | | | | | |
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| i inat in | Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Ceuse (Diseese or Injury that initiated evants rasulting in death) Last Due to (or es e consequence ot): Due to (or es e consequence ot): C. Due to (or es e consequence ot): | | | | | | | | | | | | | | | | | |
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| Pert ti. | Other signif | icant cond | tions co | entributing to o | daath bu | t not rasu | uiting in | tha un | dariying | causa g | ivan in Per | t t. | | Did tob | | ontribute 3 □ Pro | to the cause obably 42 | of deati |
| | | | | | | | | | | | | | 24a.\ | Vas an perform | autopsy ed? | a | Vare eutopsy vailable prior ompiation of f death? | to |
| | | | | | | | | | | | | | | DV a | 2 🗆 No | 1 | Tas 2 |] No |
| | es case reter | red to medi | cai | | | | | | | | 28. Ple | ce of De | eath (Check o | nly ona |) | | | |
| | aminar? Yas 2 | No | | Hospital: | Inpatiar | nt 2 🗆 | ER/Out | patient | 3□ D0 | OA O | thar: 4 N | Vursing | Home 5 CXT | Rasidar | ice 6 Oth | nar (Spec | ify) | |
| 10 | nner ot Deat Naturel Accident | c □ Dee | ding stigation | 28a. Data (Moi | | | | njury | | 28c. Inju Wo 1 [| ury at ork? Yes 2 | No | Home 5 【XRasidance 6 ☐ Othar (Specify) 28d. Describe how injury occurred Unknown | | | | | |
| | ☐ Sulcida ☐ Homicide | | investigation Found 3/4/99 Found 4P ^M Could not be detarmined 28a. Plece of Injury - At home, tarm, street, ta building, atc. (Specify) Found at home | | | | | | y, office | | | 28t. Locati City of | Stat. Location (Street and Number or Rural Routa Number, City or Town, State) 1215 W. North Ave., Balto., MD. | | | | | |
| (4 | Certifier Check only one) | | | sician: To the | e best of | my knov | wledge, | death | | | | | e, and dua to curred at the ti | tha ca | usa(s) and m | annar es | | \$) |
| 29b. S | ignature and | title of certi | | | 1 | A | | | 29 | c. Lican | nsa number | | | 29 | d. Data signa | ad (Month | , Day, Year) | |
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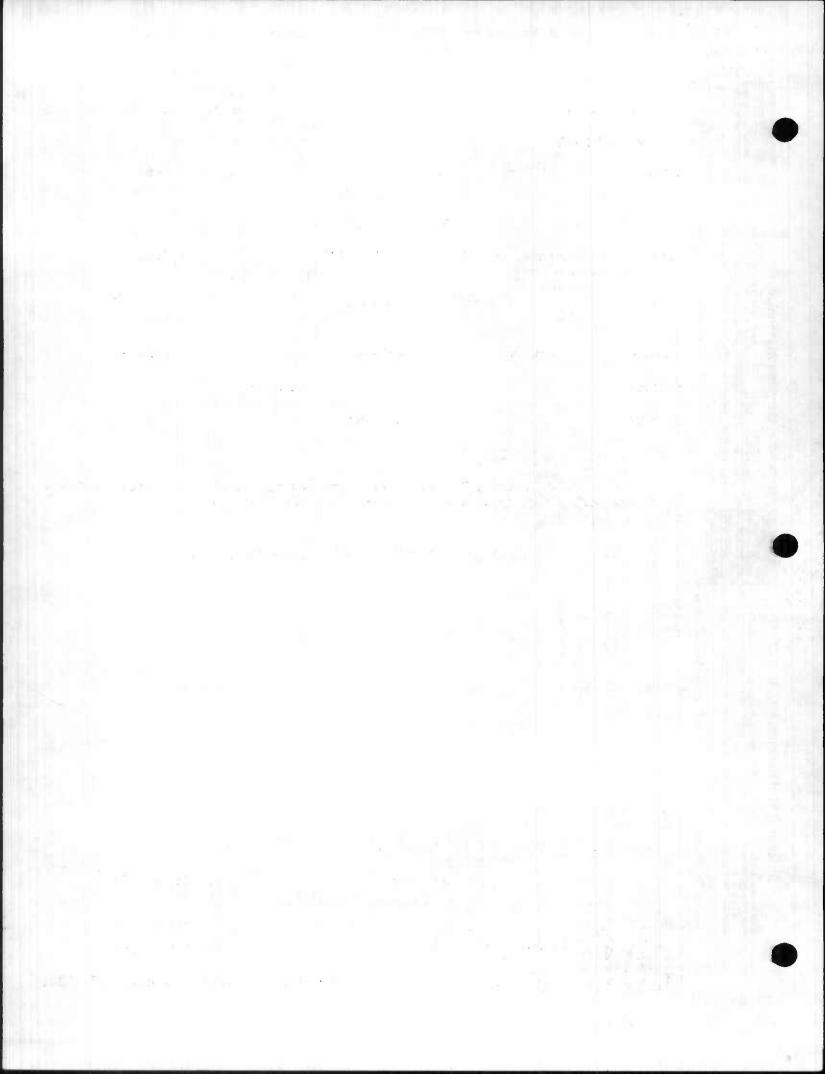
Registrar

30. Nama and apdrass ot person who completed causa ot deeth (Item 23e) (Type, Print)

32 Ragistrar's Signeture

31. Data filad (Month, Day, Year)

APR 2 0 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth Dey 4:10 AM April 17, 1999 R. McCarty, Jr. James 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) 4c. County of Deeth 21329 Middletown Road Freeland Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) XXM 2□F Months Yrs. 215 42 1751 Sept. 5, 1941 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes & No Maryland Freeland Baltimore Co. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21329 Middletown Road 21053 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? MQYes. 2 □ No 17 Yes. Give Yeer or Detes: 1960-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritel Stetus Bleck, White, etc. 1 ☐ Never Merried 🎗 🕅 Married 1 ☐ Yes 2 ☐ No Specify: Specialnite 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Eichhorn Press 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ethel Sentz James R. McCarty, Sr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Sharon B. McCarty Wife 21329 Middletown Road, Freeland, MD 21053 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Methodrof Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Oyner (Specify) Dulaney Valley Mem. Gdns Apr 21 Cockeysville, MD 22. Name and Address of Fecility 21. Signature of Futeral Service License Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 21211 23a. Pertitenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Between Onset and Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. RESPIRATORY FAILURE Immediate Ceuse (Finel disease or condition resulting in deeth) 2 YK1 PLASMA CYTOMA Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 2 0 No 3 Probably 4 Unknown 1 Yee 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

attanding physician end for use as the bunel-trensit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a peen page 2 has After this certificate funeral director, pag or Attending Physician: n 24 hours efter deeth.

e Funeral Director: After steep filled in by the fun filled in by

Physician

/Medical

Examiner

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Fig marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner man be notified at

is marked other than "natural", or

permit. Pages 1 and 2 at Department of Health and Important. If Nem 27 is n any injury or other traum

Physician /Medical

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Physician/Medical Examiner

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Certification:

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State Registrar

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72 hours after death

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steled. 29e. Certifie (Check only one)

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

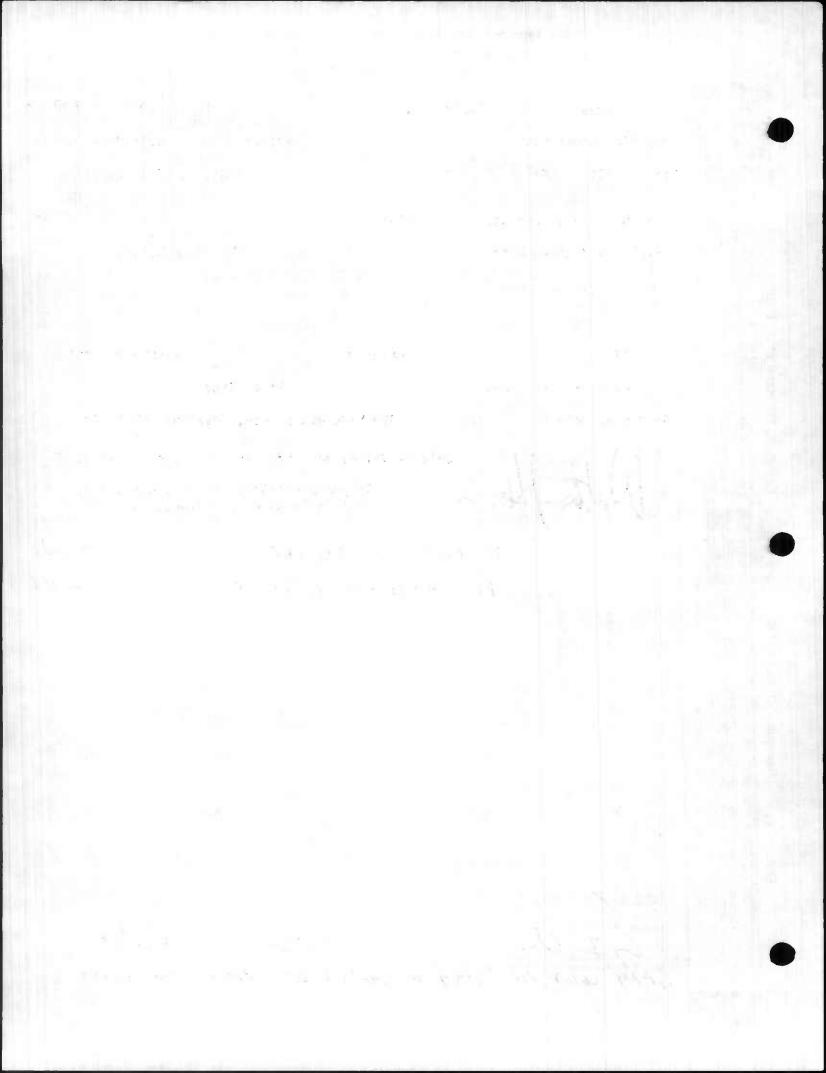
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31. Dete filed (Month, Day, Year)



DHMH 16 Rev 6/95

within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Day Physician April 1999 HWN'E Mosley

4a Facility Name (If not Institution, give street and number) An 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BON SECOURS If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** NC. 1 ☐ M 2 🕱 F Months Days 74 Yrs. 212-58-4135 3/04/25 Director Usual Residence of Decedent the Marylend 10a State 10b Count 10c. City. Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Majoral Examinal must be notified at 1X Yes 2 No Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hyglena.
Important: If frem 27 is marked other than "natural" view or other traumatic avant. 2227 W. FAYETTE U.S.A. ST. 21223 Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 Who
If Yes, Give
Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indien. 11. Marital Stetus Black, White, etc. 1X Never Married 2 Merried 1 Yes 2 No Specify: p BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER HOME 18 Mother's Name /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) TOMMY MOSLEY MARGARET SYKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Pnint) GWENDOLYN POWERS 3024 W. LANVALE ST. BALTIMORE, MARYLAND 21217 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PARK 4/15/99 BALTIMORE MD. 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Death **Physician** INTESTINAL /Medical Immediate Cause (Final CIBSTRUCTION I WEEK disease or condition resulting in death) Examiner Due to (or as a consequence of): COLON Examiner CARCINOMA The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediete cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or as a consequenca of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? Division of Vital Records, P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown ANEMIA à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen SEPSIS completion of cause of death? page 2 s MELLITUS 1 Yes 2 No 1 Yes 2 No DIABETES certificata I or Attending Physician: after death. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Denpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturel aftar daath.

Director: After in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.
2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a, Certifier 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Seth, M.D.

201, WISE AVENUE

BALTIMORE

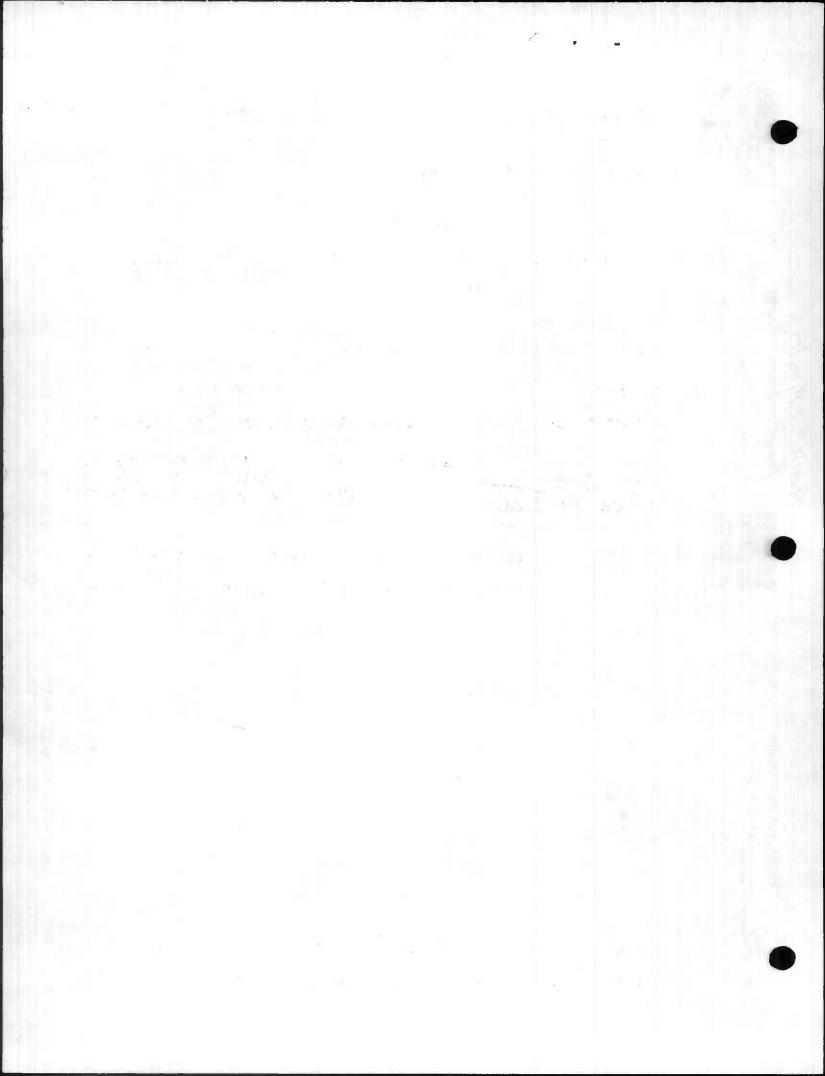
MD 2122

State Registrar 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Date filed (Month, Dey, Year) 32 Registrar's Signeture

DEEPAK

SETH, M.D.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Birthplace (Stata or Foreign Country)

10d. tnslda City Limits

1 Yas 2 No

MD.

5:50 A.M

19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20c. Location - City or Town, Stata BALTIMORE MD. 22. Nama and Addrass of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 Approximata Intarvat Between Onset end Death months 23b. Dfd tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilabla prior to complation of cause of daath? 1 ☐ Yas 2 ☐ No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and placa, and dua to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daath occurred et the time, date and placa, end due to the cause(s) and manner stated. 29c. License number 29d. Data signad (Month, Day, Year) D-40521 pril 16,1998 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) 3350 Wilkers Arence Swite 302 Bottimore, MD 21229

State Registrar

Medicai

29a. Certifiar

29b. Signature and titla of cartified

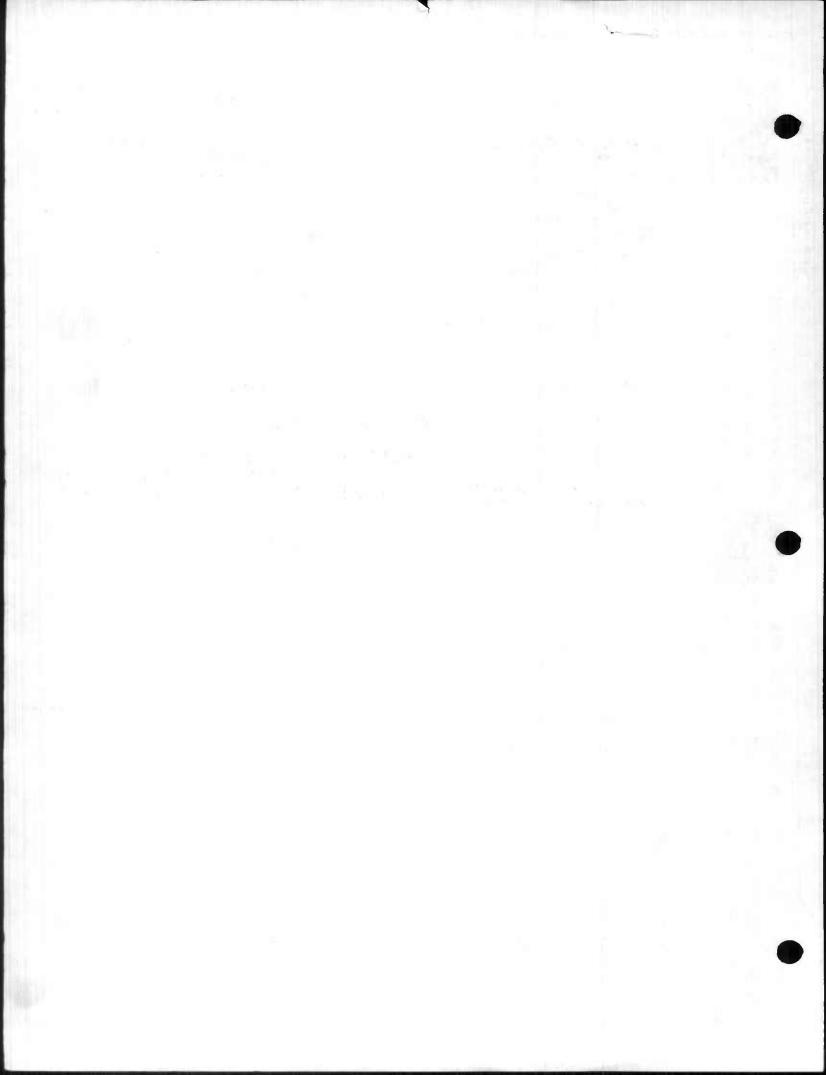
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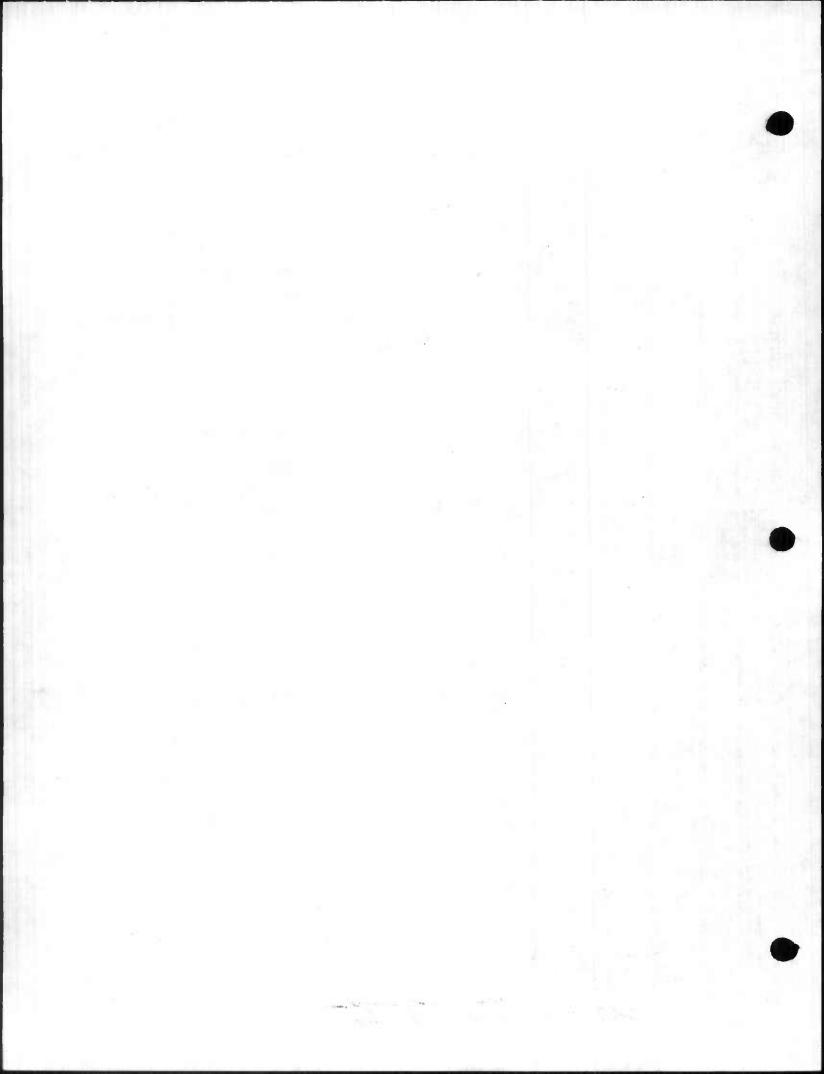
32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 13 03 5

| | | | | | Certifica | te of | Death | | Re | g. No. | 1 | 0000 | 9 | | |
|--|-----------------|--|--|--|---|----------------------|--|-----------------------------------|-------------------------------|--|-------------------------|---|-------------------------------|--|--|
| | | 1. Decedent's Neme (First, Middle, Las | st) | | | | | 2. Date of | of Death | | V | 3. Time of D | Jeath | | |
| Physicia | | Howard | | Mar | shall | | | Montl 04 | _ | Day 19 - | Year 99 | 7:20 | a.m | | |
| /Medic Examin | | 4e Facility Name (If not institution, give | e street and number) | 1 | | • | 4b. City, Town, | or Location of | Death | 4c. Count | | 7.20 | C | | |
| | | 2703 E. Federal | ore | e None | | | | | | | | | | | |
| Funeral Director | | 5. Social Security Number 226-28-9389 Usual Residence of Decedent | ex IXIM 2□ F | (In yrs. last bir | Yrs. Months | Deys | | in. (Mont | of Birth h, Day, 1 02-2 | | 9. Birth Cou Virg | place (State or I ntry) inia | Foreign | | |
| deeth with the Maryland rrs 23a or 28s-f ahow rrs 15s nortified at | or | 10a. Stete 10b. County 10c. City, Town or Location | | | | | | | | | | | 10d. Inside City 1 Yes 2 | | |
| 158 P | Director | 10a. Street and Number | 1 | Dar | | p Code | | | 10 | g. Citizen of | zen of What Country? | | | | |
| 13 w 17 | D I | 2703 E. Federal S | St. | | | 2 | 1213 | | | USA | A | | | | |
| 5 2 2 | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ev Armed Forces? 1 (2) Yes 2 (1) No If Yes, Give Year or Detes: | - | 13. Wes Dece ff Yes, spi | | Hispanic Origin? ban, Mexican, Pu Specify: | (Specify Yes o ento Rican, etc | ck, White, | ce - American Indian, ck, White, etc. y: Black | | | | | |
| Maryland 21215-UUZU nd 2 should be filed within 72 hours af till bend Marels bygiene. Z7 is marked other than 'natural', or r traumatic event, the Maricial Exam | Completed | 15. Decedent's Ed (Specify only highest gre | de completed) | | Decedent's Usu (Give kind of w life, DO NOT | iel Occu ork doni | pation during most of (ed) | vorking | 11 | 6b. Kind of B | lusin ess/i n | dustry | | | |
| with the same of t | E | Elementery/Secondary (0-12) | College (1-4or 5+ |) | Steelwo | rke | r | | | Bethle | thlehem Steel | | | | |
| The High | Ö | 17. Father's Neme (First, Middle, Last) | | | - | | _ | Neme (First, M | | | | | | | |
| should be and Mentel or marked or umatic eve | To Be | James Mars | shall | | | | Sa | rah T | yree | ree | | | | | |
| Show Show | - | 19a. Informent's Neme/Reletionship (| Type, Print) | 19b | . Meiling Addres | s (Stree | at and Number or | | | | , State, Zij | Code) | | | |
| Te, Mi | | Mrs. Elsie Marshal | 1 / Wife | 27 | 703 E. H | ede | ral St. | Baltime | ore, | Mary | Land | 21213 | | | |
| Saltimore, semit. Pages 1 er Department of Hear Important: If Item inty injury or other ance. | | 20a. Method of Disposition | Removal from State | 20b. Plece of cemeter | Disposition (Nerry, cremetory or | me of other pl | ece) | Date | 2 | Oc. Location | - City or To | own, State | | | |
| Fame Family (fury) | | 4 □ Donetion 5 □ Other (Specif) | 0 | Wo | oodlawn | 4-23- | 99 W | oodlav | m, M | aryland | | | | | |
| Depentit. Depentrimportu | | 21. Signature of Funeral Service Licen | C. / | | The De | rri | ess of Fecility ck C. Jo Heights | nes Fu | nera Balt | 1 Home | Md. | 21215 | | | |
| | | 23a. Pert1. Enter the diseese, or companies shock, or heert feilure. List only | plicetions that can sed to | he deeth. Do r | | | | | | | | Approximate Interval Between | | | |
| Physician | | American Communication | | | V | | | | | | 1 | Onset and De | SERTI | | |
| / /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in deeth) | · non- | Hode | Kins | 1 | w by | oma | - | | 1 | 1200 | 22 | | |
| | _ | Due to (or as a consequence of): | | | | | | | | | | | | | |
| ured | amine | Sequentially list conditions | b | ue to (or as a | consequence of | : | | - | | | - 1 | , | | | |
| The Colds, P.O. DOX 06/00, The law requires that the death certificate be executed that been signed by the attending physicien and page 2 should be detached for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or as e consequence of): | | | | | | | | | | | | | |
| BOX OC leath certifice attending pt of for use as ti | 5 | d | | | | | | | | | | | | | |
| death death dfor | icia | Pert II. Other atgniftcant conditions of | 23b. | 23b. Did tobecco use contribute to the cause of deat | | | | | | | | | | | |
| od by the | / Physician/ | | | | | | | | 1 🗆 Ye | 1 | | bably 4 U | | | |
| necords, P.C. BO) he law requires that the death ce a has been signed by the attendi sge 2 should be detached for use | Completed by | | | | | | 1 = | | Was an perform | autopsy ed? | 37 | fere autopsy fin railable prior to ompletion of cau death? | | | |
| The lay | E | | | | | | | | 1 Yes | 2 0000 | 1 | Yes 20N | ło | | |
| vician: The | Bec | 25. Was case referred to medicel | | | | | 26. Place of I | Deeth (Check | only one |) | | | | | |
| s certain | To | examiner? | Hospitel: | t 2□ER/Ou | rtpatient 3 D | OA O | thor | Home 5 | | | her (Speci | (v) | | | |
| | | 27. Mervner of Deeth 1 Natural 2 Accident 5 Pending investigation | 28a. Dete of Injury (Month, Day | | l'ime of njury M | 28c. Inj W | ury et ork? Yes 2 No | 28d. Desc | cribe hov | v injury occu | berned | | | | |
| or Atte | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injur building, etc. | y - At home, fa (Specify) | rm, street, fecto | ry, offici | | 28f. Locat City of | tion (Str or Town, | eet and Num State) | ber or Rur | al Route Numb | 0 7, | | |
| To the Hospital or Attending R within 24 hours after death: To the Funeral Director: After completely filled in by the funer | edical (| 29e. Certifier (Check only one) 1 Certifying Physics Certifying Physics 2 Medical Example (Check only one) | ysician: To the best of hiner: On the basis of e end menner stete | xaminetion an | death occurred | at the | time, date end ple opinion, deeth o | ace, and due to ocurred at the | the car | use(s) and m te and place | enner as : | stated. to the cause(s) | | | |
| vithir of the | Me | 29b. Signeture end title of certifier | 51. | 2 | 25 | c. Licer | nse number | | 29 | d. Date sign | ed (Month, | Day, Year) | | | |
| ->-0 | | E. Wind Os | En W. Jun, m.D. 044629 | | | | | | | 4/20 | 90 | 7 | | | |
| REP | | 30. Neme and address of person who | completed cause of dea | ath (Item 23a) | (Type, Print) | | . Wolfe | St 1 | Bal | tuma | ie. | Q m | | | |
| Stat | te | 31. Date filed (Month, Dey, Year) | 32 The sistrar | 's Signeture | W.C. | | . 00011 | | | 4 | | | | | |
| Registra | | APR 2 1 1999 | Ener | a L | · Kar | | | | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month April 7:35 PM Belva E. Mc Cormack 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth University of Maryland Madical System Baltimore util Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) if Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Months 1 ☐ M 2 🛛 F 1930 Maryland 214-26-3225 68 Sept. 16, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 No Maryland Baltimore Lansdowne 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21227 4002 McDowell Lane Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Maritel Stetus Armed Forces? 1 Yes 2 No ff Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Thelma Talbott Lloyd Gore 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Baltimore, MD 21227 Lawrence F. McCormack 4002 McDowell Lane, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/20/99 Loudon Park Cemetery Baltimore, Maryland 22. Name and Address of Fecility Loudon Park Funeral Home 21. Signature of Faneral Service Licensee 3620 Wilkens AVenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final Sepsis disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequenca of) Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown myocardial Infarction 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 SNatural Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide

physician end s the burial-transit requires that the death certificete be executed ettending ; 98 signed by the certificete

Physician /Medical

Examiner

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

29a, Certifier

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

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8

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: If lem 27 is marked other than "natural", or here any injury or other traumatic

Division of Vital Records, P.O. Box 68760 al or Attending Physician: T s effer death. If Director: After this certificet filled in by the funeral e Hospital o 24 hours et e Funeral Di To the To the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4611 Roland Avenue 31. Date filed (Month, Dey, Year)

29b. Signature end title of cartifier

32. Registrar's Signature

Apartment #3

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and menner es stated.

2 Medical Examínar: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

Baltimore, MD

APR 2 1 1999

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Victor Leo McCoy 17, 1999 9:05pm April 4e. Fecliity Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Home

Hagerstown

Wasi

7. Age (In yrs. last birthday)

Months Deys Hours Min. September 13,1928 Colton Villa Nursing Home Washington Birthplece (State or Foreign Country)
 WV 5. Sociel Security Number 1**愛**M 2□ F 236-40-8319 Usuel Residence of Decedent 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Washington Hancock 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3909 Resley Road 21750 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorcad White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Crane Operator Sand Mining 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Stanley B. McCoy Mildred D. Ambrose 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Resley Road Hancock, MD 21750 leca of Disposition (Name of Dete 20c. Loc Nancy L. McCoy/Wife 20b. Pleca of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Removel from State St. Paul's Lutheran 4 ☐ Donetion 5 ☐ Other (Specify) 4/21/99 Hancock, MD 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Grove Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediate Cause (Final · ATHEROSCUBROTIC CARDIO VASCULAR DISBASE diseese or condition resulting in deeth) CHRONIC OBSTRUCTIVE AIRWAY DISEASE. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): ATRIAL FIBRICIATIONS

Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner buriel-transit

pue

ettending physicien for use es the burie

signed by t

cate hes been sig, page 2 should b

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatiety filled in by the funeral director;

To the Funeral Dir

the

Medicai

29b. Signeture end title of certifier

MANZAR

Mouren

requires that the death certificate be exec

P.O. Box 68760

Records,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinal must be notified at

permit. Peges 1 end 2 should be filed within: Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "nany injury or other traumatic event, it is Med

the Meryland

72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical by Completed Be P Certification:

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a, Certifier

State Registrar

J SAAPI 31. Date filed (Month, Day, Year) 32. Registrer's Signature APR 2 1 1999 >

30. Name end eddress of person who completed cause deeth (Item 23e) (Type, Print)

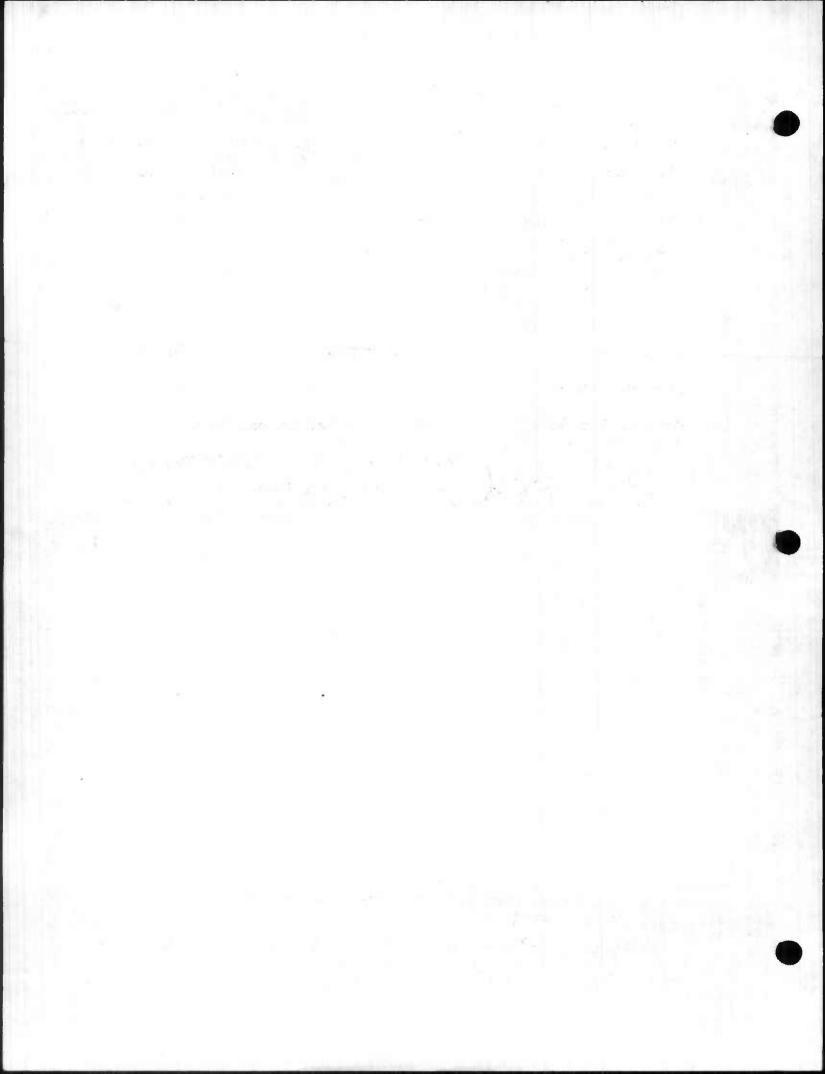
29c. License number

028365

368 MILL STREET HAGERSTOWN MD21740

29d. Dete signed (Month, Day, Year)

4. 18.99.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 2 UNL Month MC G-RATH 10:00 AM April 1999 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Medical 5. Social Security Number Center. Baltmore Balhmore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) Deys Months 1□ M 2□ F 214-14-7606 Yrs. Feb. 18, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d, inside City Limits Maryland N/A 1 ☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1800 Swansea Road 21239 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca -11. Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller 12yrs. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) William Mc Grath Myrtle Calder 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Jim Mc Grath / Nephew 7500 Paseo Escondido Prescott Valley, Az. 86314 20b. Place of Disposition (Neme of 20e. Method of Disposition Data 20c. Location - City or Town, Stata cematary, crametory or other piece) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Episcopal Ch. Cem. 4/23/99 Long Green, Maryland 21. Signature of Fungral Service Licent 22. Name and Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximate Intervel Between Onset end Death Immediata Causa (Final disease or condition rasulting In death) Urenja Due to (or es a consequenca of): Myocardial Menchan Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaesa or Injury that Initiated avants resulting in death) Last Due to (or es e consequance of): Dua to (or es a consequence of)

Physician /Medical Examiner

other

6 permit. Pege Depertment of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

Directo

Funeral

by

Completed

Be

with the Meryland

death

Peges 1 and 2 should be filed within 72 hours effernent of Heelth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite

altimore, Maryland 21215-0020

physician and s the buriel-transit 98 950 0 ed by the e signed by certificate has been si irector, page 2 should i Hospital or Attanding Physician:
24 hours efter death.
 Funeral Director: After this certifice

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical þ Completed Be 2 filled in by the funeral Certification:

4 Homicide

29a, Cartifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of causa of death?

2 1 No 1 ☐ Yes

1 ☐ Yas 2 No

25. Was case raferred to medical exeminer? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpetient 3 DOA 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

27. Mannar of Daath Data of Injury (Month, Dey Year) 1 Naturel 5 Pending investigation 2 Accident 6 Could not be datermined 3 Suicide

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and dua to the cause(s) and menner stated. 29b. Signature end title of cartifier 29c. License number

29d. Date signed (Month, Day, Year) APRIL 201, 1999 98026

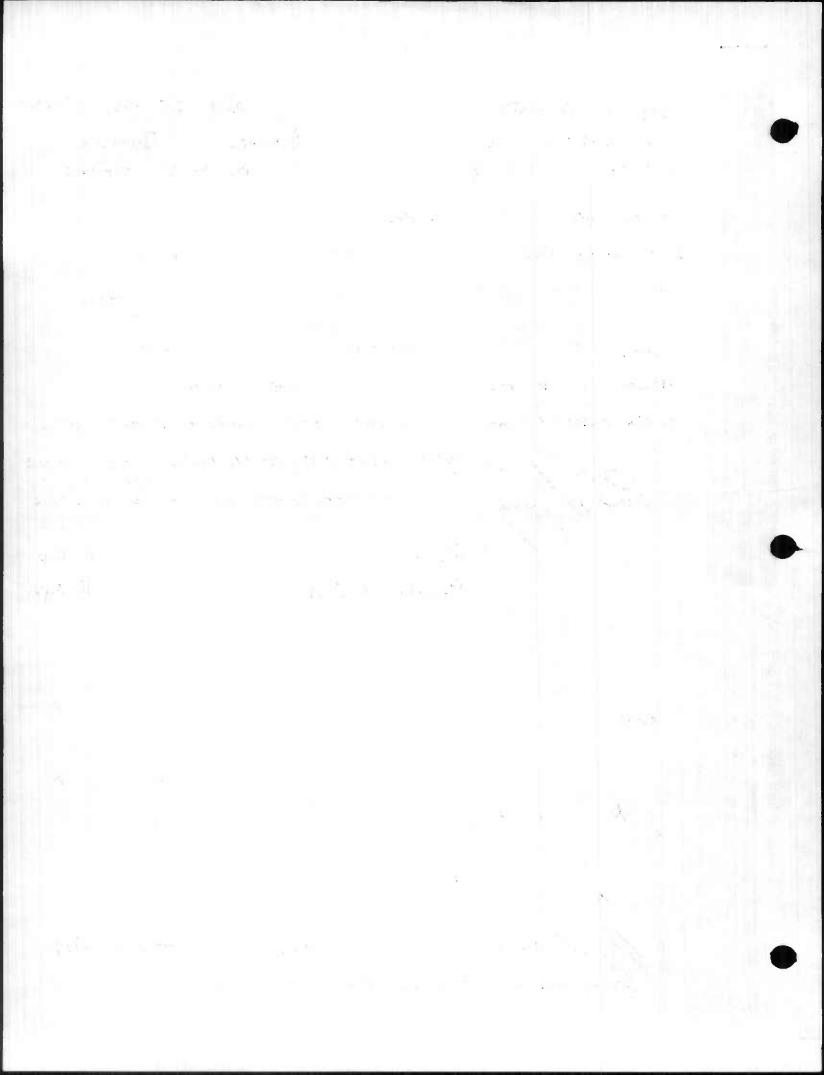
164-1 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

4940 SMUDAY Bryvici Medical Conk GARUSA. Averbe Gasten 31. Date filed (Month, Day, Year) 32. Re APR 2 1 1999 32. Registra s Signatura -per

State Registrar

Medical

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 2 NOOIV SYDNEY MARCUS APRIL /Medical 4a Facility Neme (If not ipstitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Nursing Home LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Deys Yrs. 158-07-7909 82 Director NEW JERSEY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2 No 28e-fr Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 6105 WESTCLIFF DR. 21209 flams 23a USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes X☐ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens important: if Item 27 is marked other than "n any Injury or other traumatic aware as a brown Elementary/Secondary (0-12) Cottege (1-4or 5+) MARKETING BEVERAGES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARCUS **ALEXANDER** SARA TURNDORF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) MARION MARCUS (WIFE) 6105 WESTCLIFF DR. BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4/18/99 OHEB SHALOM MEM. PARK REISTERSTOWN. MD 4 Donation 5 Other (Specify) 22. SOL and Address of Society BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Pertil. Enter the company of company shock, or heart failure. List only one ations the carried the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, cause or each line. Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical RRAM FAILUNG Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of). Box 68760, Due to (or es e consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 | Yee 2 | No 3 Probably 4 Unknown Dehydretia Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed & Urrang Truck Intelior 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No SIP CUA Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this To the Hospital or Attending P? within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Peath 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 DMatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 4 Homicide edical 1 Scrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

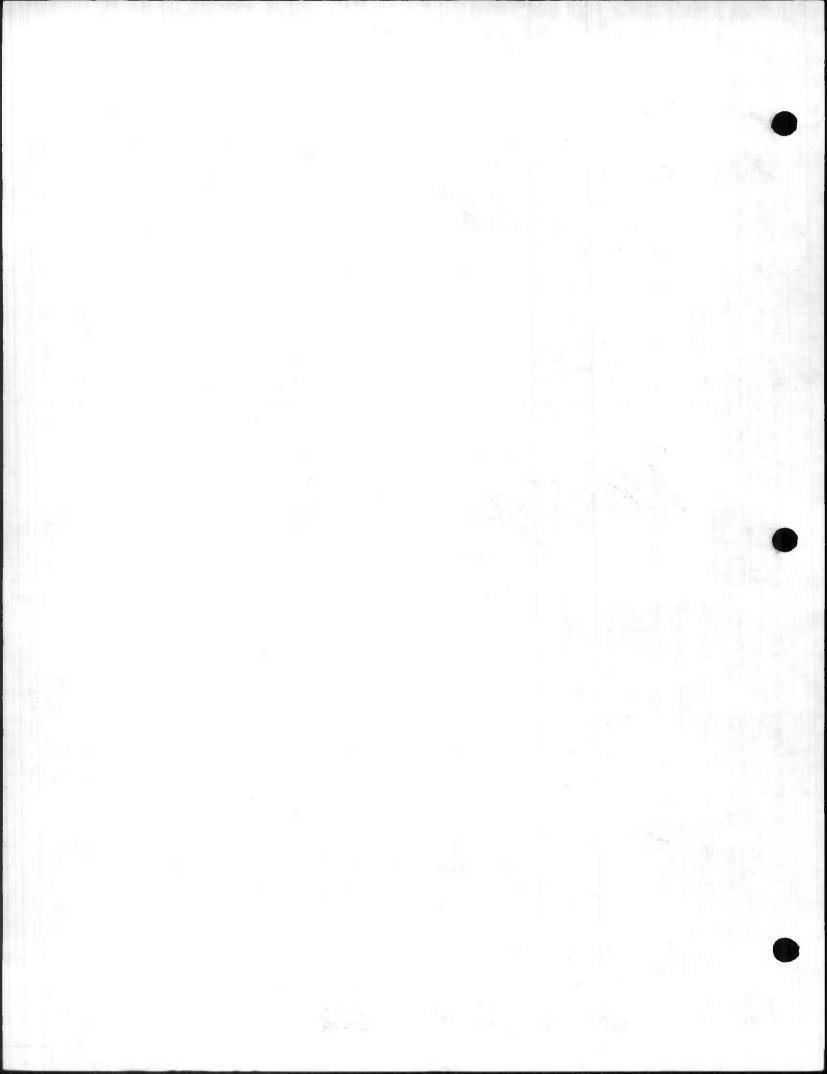
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed cause of deeth (Item 23a) (Type, Print) T. Fineman Lutheralle md 21093 5757 Fill nd 31. Date filed (Month, Day, Year)

State Registrar **DHMH 16 Rev 6/95**

APR 2 0 1999

32. Registrer's Signeture

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Yaar MITCHELL APR 1999 MILLER 16 14:05 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Undar 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1**X**0 M 2□ F Yrs. 577-48-2823 90 N. CAROLINA AUG 5, 1908 Usual Rasidance of Dacedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MONTGOMERY BETHESDA 1 Yas 2 □ No 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 8100 CONNECTICUT AVE., #508 20815 USA 12. Wes Decedanf Evar In U,S. Armed Forcas? 14. Race - American Indien, Bleck, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Naver Merried 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Detas: 1 ☐ Yas 2 ☐ Xio Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) 12 MERCHANT RETAIL 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumema) HARRY MILLER FANNIE UNKNOWN 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) MOLLIE MILLER (WIFE) 8100 CONNECTICUT AVE #508 BETHESDA, MD 20815 20b. Plece of Disposition (Nama of cametary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 durial 2 Cremetion 3 Ramovai from Stata 4 Donation 5 Othar (Specify) 5 Othar (Specify) SHAAREI TFILOH 4/18/99 BALTIMORE, MD eral Service Li 22 Name and Address of Facility BROS., INC. 21. Slana 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 duling that ceused tha daath. Do not antar tha mode of dying, such as cardiac or respiretory arrest, Approximete Intarval Batween Immediata Cause (Finat disaase or condition resulting in death) ZUV YEars Sequentially list conditions, if any, leading to Immadiata causa. Entar Undarlying Ceuse (Disaasa or Injury thet initiatad avents rasulting In death) Last Dua to (or es e consequence of) Dua to (or es a consaquance of) 23b. Did tobacco use contributa to the cause of death? 1 Yee 28 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 100 moratory 1 Yes 28 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Minpatient 2□ ER/Outpatient 3□ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding 1 ☐ Yas 2 ☐ No investigation

P.O. Box 68760. Records, this certificete Division of Vital director.

4116199

Mitchell Miller

Examiner after death.

Director: After this certifice filled in by the funeral

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

2

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examines must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Ilem 27 is marked othe any liury or other traumatic event potes.

Physician /Medical

Examiner

filed within 72 hours efter

21215-0020

Maryland

Baltimore,

Physician/Medicai Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was cese rafarred to medical axaminar? Be 2 1 ☐ Yas 2 No 27. Manner of Death Medical Certification: 1 Naturai 2 Accidant 3 Suicida 6 Could not be 28f. Location (Straat end Number or Rurat Routa Number, City or Town, State) 28e. Ptece of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida

12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated.

29c. Licansa number

7206017

29d. Data signed (Month, Dey, Year)

State Registrar

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

> 31. Dete filed (Month, Day, Year) APR 2 0 1999

29b. Signatura and title of certifier

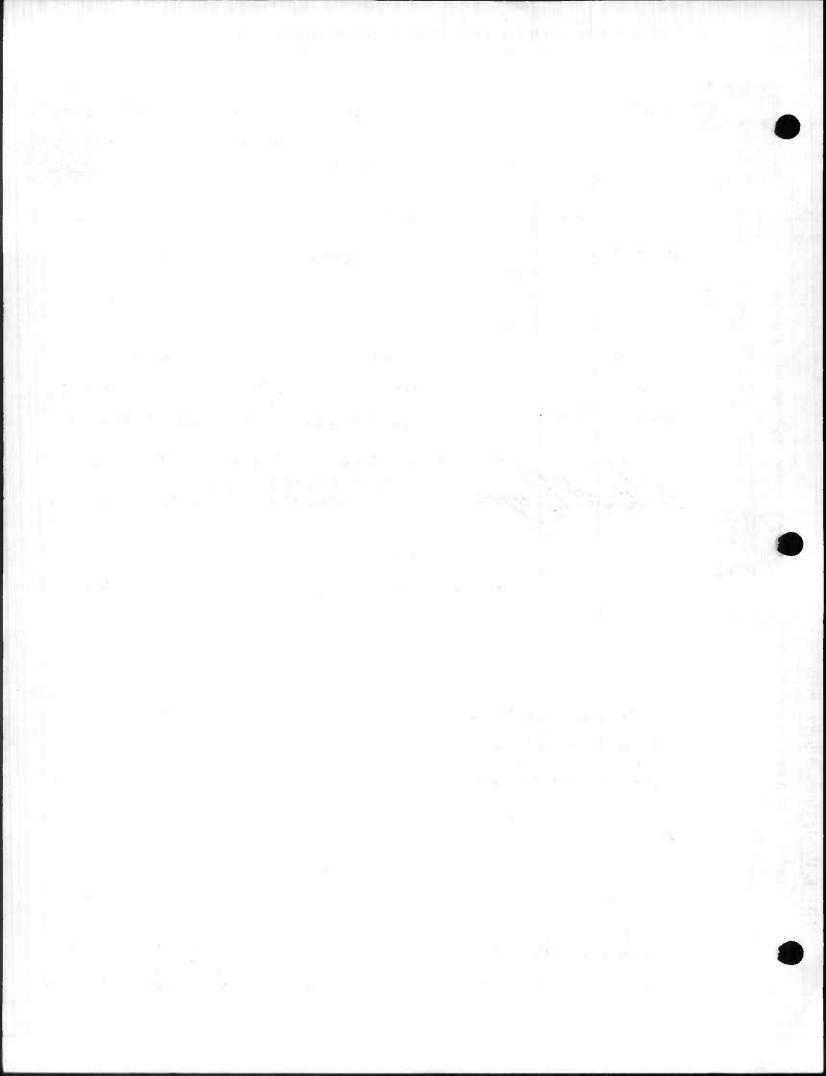
29a. Cartifian

1 anner ma

30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print)

HARRIS MENNEY, K.D. 5454 W. 5454 Wisconin tos Chery Chase MD 20815 32. Registrar's Signatura

DHMH 16 Bay 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MOORE 01:10PM APRIL 19 1999 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number, 4c. County of Death Examiner HOSPITAL BALTIMORE ST. AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey). Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 M 2 VF Months Days 240-03-8407 Usuat Residence of Decedent Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at MD 1 Nes 2 No Director LTIMORE 10e. Street end Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours aftar death with I Department of Health and Mental Hygiena. I important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event. 21216 Funeral 12. Wes Decedent Ever Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married AFRICAN 1□ Yes 22 No Baltimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondery (0-12) College (1-4or 5+) 6 DMESTIC 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Maddie Jones OL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Balta 141) 21218 James Jones 20a. Method of Disposition

1 O Turial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Mem 22. Name and Address of Facility
Albert P. W 21. Signature of Funeral Service Licenses 231 Fart1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate tntervet Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting In deeth) /Medical ASPIRATION PNEUMONIA DAYS Examiner Due to (or as a consequence of): Examiner DYSPHAGIA DAYS sician and burial-transit certificate be axecuted Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760 physician ACUTE CEREBROVASCULAR ACCIDENT DAYS Physician/Medical the Due to (or es e consequence of): use as 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Denknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 ☐ Yes 2 € No 1 ☐ Yes 2 ☐ No After this certificata or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P₀ 1 Diffipationt 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatl 8 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours a Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. To the Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

IDA MOORE

MOHAMMAD Y, KHAN, M.D. 900 CA 31. Dete tiled (Month Dex Year) APR 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

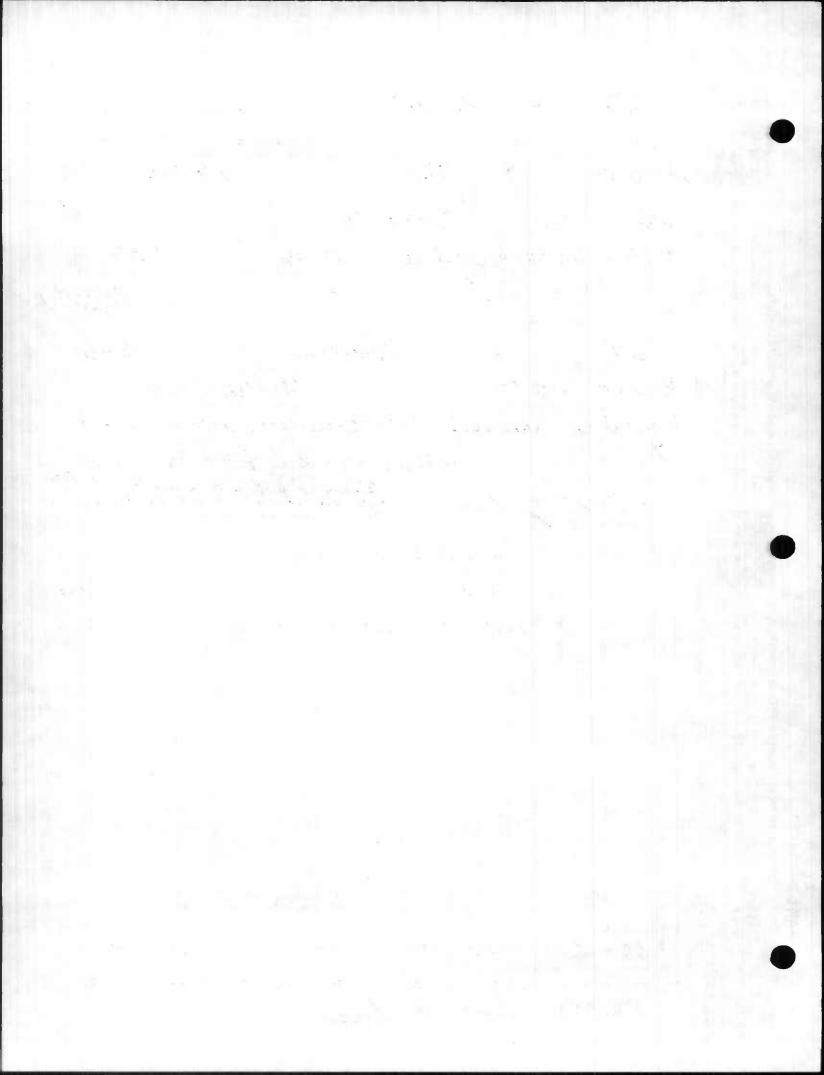
900 CATON AVENUE, BALTIMORE, MARYLAND 21229

Stores Signature

MEDICAL RESIDENT

P12593

APRIL 19, 1999



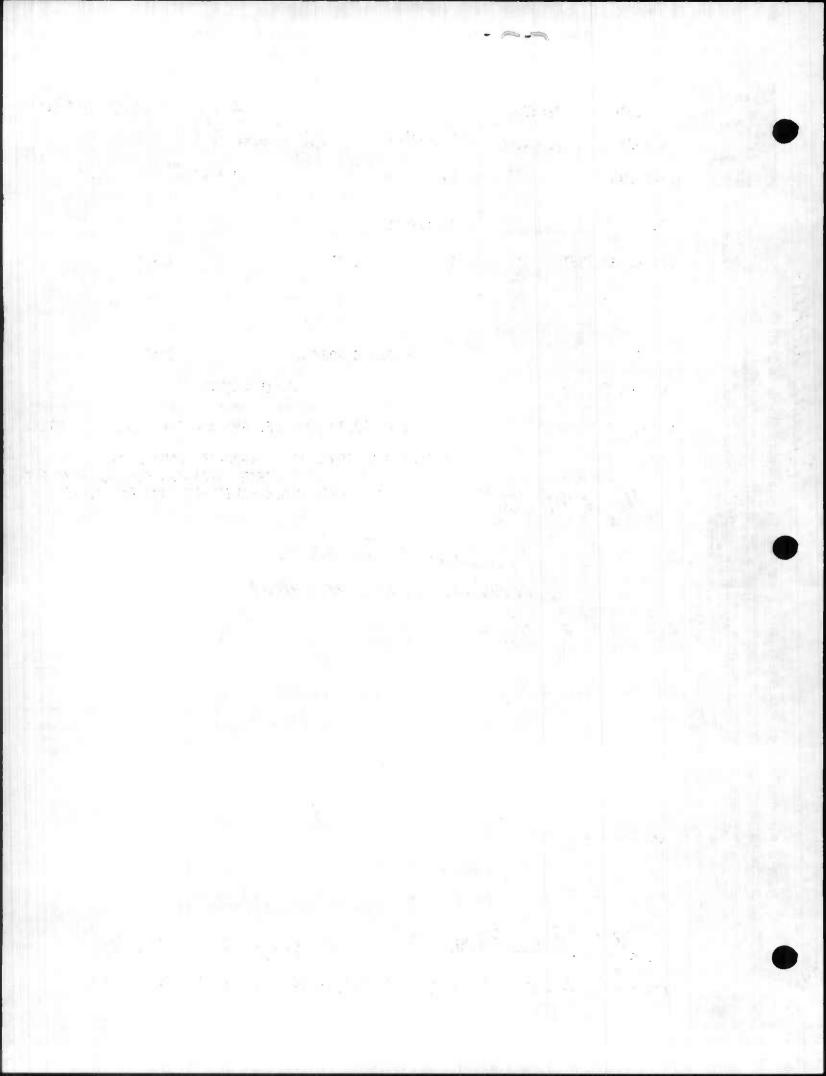
Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physicianon ELEANOR M. NICKENS /Medical 4b. City, Town, or Location of Deeth, 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Baltimore City reneral 4/and 5. Sociei Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 X F -7-1915 MD 83 **Director** 212-26-7833 Usuai Residence of Deceden the Manyand 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 No Yes 2 No Director MD. BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code S.A. 14. Raca - American Indien, Black, White, etc. Funeral 701 N. ARLINGTON AVE. APT506 21217 12. Was Decedent Ever in U,S Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) - leanor Nickens 1 Yes 2 No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 Å Divorced BLACK Completed 16e. Decadant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) DOMESTIC WORKER HOME 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Sumeme) . Pages 1 end 2 should be fil ment of Heelth and Mental H ant: If item 27 is marked oth Be GEORGE RUSTIN JANIE RUSTIN 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 701 N. ARLINGTON AVE. APT 506 BALTIMORE, MD. 21217 ce of Disposition (Name of Date 20c. Location - City or Town, State CATHERINE MAJOR 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 1XOBuriei 2 Cremetion 3 Removel from State 9 MARYLAND NATIONAL PK. 4-23-99 LAUREL MD. 4 □ Donetlon 5 □ Other (Specify) any Injury 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or having failure. List only one cause on each line. Approximeta Intervei Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Examiner physician end the burial-Iransit Sequentielly list conditions, if eny, laading to immediate cause. Entar Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest the death certificate be exec P.O. Box 68760 Physician/Medical 98 USB o signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, À 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was en eutopsy performed? Completed page 2 s hes 212 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Pleca of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this funerel 28a. Dete of Injury (Month, Day Yaar) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending efter death. 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicida 24 hours Hospital 29e. Cartifiar (Check only one) 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end piece, end due to tha ceusa(s) and menner es steted Medical 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. completely To the To the To the 29b. Signetura and titla of certif 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person, who completed cause of deeth (tem 23a) (Type, Print) nacyland General Hospital

mer

DHMH 16 Rev 6/95

State

Registrar



Funeral Director

28a-f show

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalith and Mantal Hyglena. Important: If item 27 is merked other than "natural", or itema 23a or 28a-f show any highry or other traumatic avent, if a Medical Examination in an once.

ALFRED G.

NICKEL

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner Completed by Physician/Medical Examiner been signed by the attanding physician and should be detached for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has it completely filled in by the funeral director, page 2 s Be 2 Medical Certification:

| | | | State c | i Mary | | - | | | nealth Death | | dental Hy | /gier Reg. / | 2 | 9 | 3043 |
|--|---|--|---|------------------------|--|---|-------------------------------|----------------------|--------------------------------------|------------|--------------------------------|-----------------|------------|---|--|
| 1. Decedent's Na Alfred | me (First, Midd Gusta | | kel | | | | | | | | 2. Data of D Month April | - [| Day 17 | Year 1999 | 3. Time of Death 11:53AM |
| 4a Facility Name St. Agn | | | | mber) | | | | | | | Location of Death imore Baltim | | | | e City |
| | . Social Security Number 212-26-8159 6. Sex 7. A | | | | | ge (In yrs. lest birthday) 70 Yrs. If Under 1 Year If Undar 24 Hrs. Months Days Hours Min. | | | | | | irth ay, Yea | 929 | 9. Birthpl Count Bal | laca (Steta or Foreign try) timore MD |
| Usual Residenca | of Decedent | | | | | | | | | | | | | | |
| 10a. State MD | 10b. Count | y /a | | 10c | City, Town | timo | | | | | | | | 10 | 0d. Inside City Limits 1 No Yes 2 No |
| 10e. Street and N | lumber | | | | | | 10f. Zie | Code | | | | 10g. (| Citizen of | What Coun | try? |
| 2738 Wa | shingt | on B1 | vd. | | | | | 212 | 30 | | | | Unit | ed St | ates |
| | rried 2 Ma | ırrled | 2. Was Dec Armed Fo 14 Yes If Yes, Gi Year or D | 2 No | n U,S. | If | /as Dece Yas, spe □ Yas | cify Cub | lispanic Or an, Mexica Specify | n, Puarto | ecify Yes or N Rican, etc.) | 0- | | ce - Amarica ack, Whita, a fy: wh | |
| (Sp | 15. Decede ecify only high | nt's Educa | ition co <i>mpleted)</i> | | 16e. | Decede (Give k | ent's Usu | al Occup ork done | ation during mos | st of work | ing | 16b. | Kind of E | Business/Ind | lustry |
| Elementary/See | condary (0-12) | | College (| 1-4or 5+) | nechanic | | | | | | | | Machi | nary | |
| 17. Father's Name Carl F | e (First, Middle rederi | | cke1 | | | | | | | | e (First, Middle Emma S | | | me) | |
| 19a. Informent's | | | | | | | | | | | ore, Ma | | | | |
| | isposition 2XXX remation 5 \(\text{Other} \) | | moval from | State | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 4/20/99 Brentwoo | | | | | | | | | | |
| 21. Signature of t | Funefal Service | a Grange | 200 | In | 0 | | | | rk Fu , Mar | | 1 Home d 2122 | 36 | 520 W | ilken | s Avenue |
| 230 Part1. Enta shock, or he | r the disaasa, c eart failure. Lis | or complications on the contraction of the contract | ations that of cause on o | caused the deach line. | leath. Do | not ente | er the mo | da of dyi | ng, such as | s cardiac | or respiratory | arrest, | | 1 | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | UPPER GI BLEEDING | | | | | | | | Hours | | |
| | , | | | Due | lo (or as a | consequ | uenca of) | : | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | Due to (or as a consequenca of): | | | | | | | | | | |
| Cause (Disease that initiated ever resulting in death | or injury hts) Last |) °. | | Dua t | o (or as a | onsequ | ience of): | | | | | | | | |
| | | d. | | | | | | - | | | | | | | |
| Part II. Other sign | nificant condit | lons contr | ibuting to d | eath but not | resulting Ir | the un | derlying | cause gi | ven in Part | 1. | 23b. Die | d tobac | co use c | ontribute to | the cause of death |

death? 4 Unknown 1 Yes 2 No 3 Probably

24e. Was en autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of deeth?

2 No

Yes 2□ No

25. Was case referred to medical exeminer?
Yes 2 No
27. Menner of Death 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 3□ DOA Inpatiant 2 ER/Outpatient 28b. Time of Injury 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury al Work? Natural 2 Accident 5 Pending Invastigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifler (Check only one)

The Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

D04964

29c. License number

29d. Date signed (Month, Day, Year) April 19, 1999

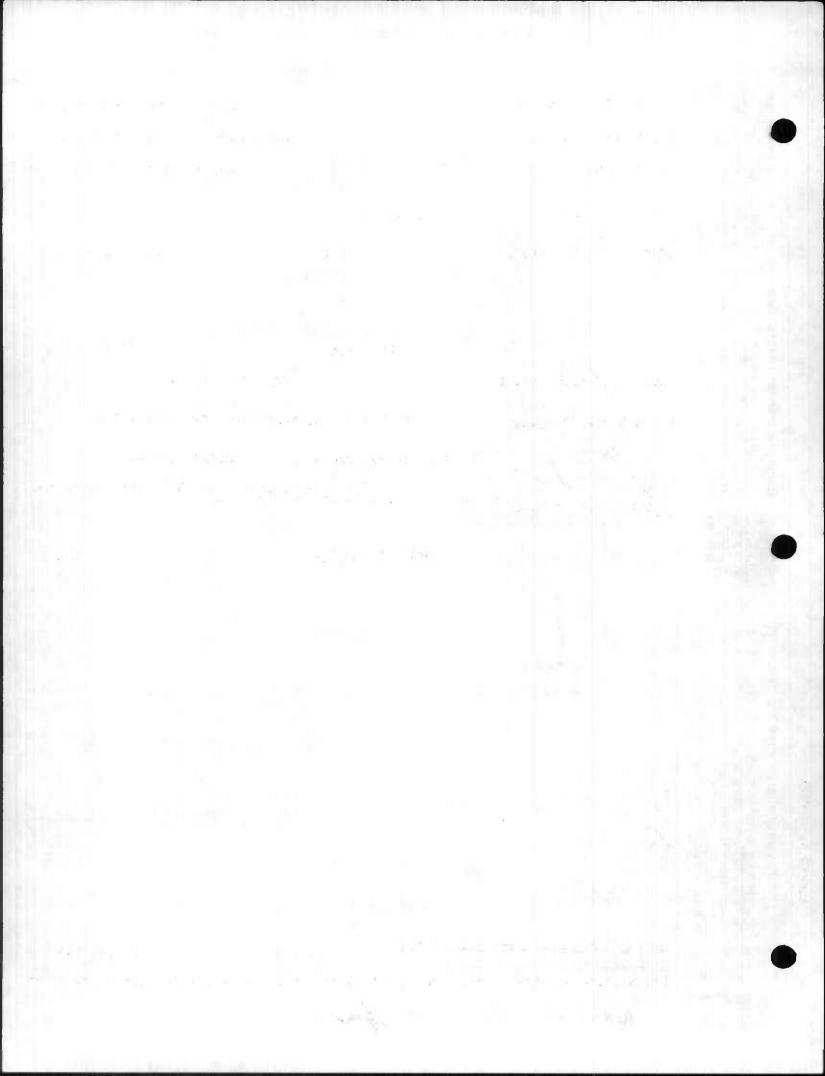
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. William J. Hicken St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year) **APR 2 1** 1999





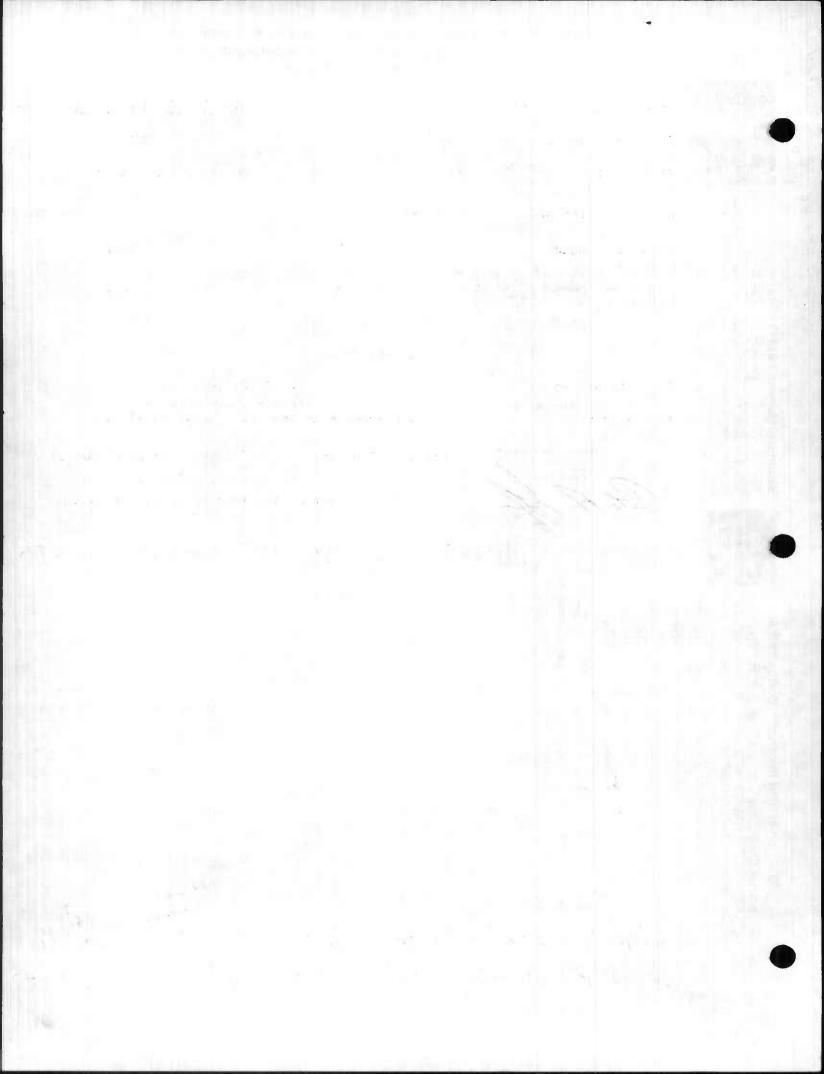
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

| 1. Decedent's Name (First, Middle, Last) Erna Katherine Nortrup 4. County of Death Month Fallstom General Hospital 5. Social Socially Name (Inchestation) by Septent and number) Fallstom General Hospital 6. Social Socially Name (Inchestation) 7. Aga (In yrs. Set birmodey) 8. Oris. 9. Oris. | | | | Olale | or iviaryia | | Certificat | e of | lealth and I Death | | Reg. No. 9 9 | } | 1301.1. |
|--|----|--|--|--|--|--|--|---|--|--|---|------------------------------|--|
| Erms Katherine Nortrup 4 a Fashly Name (Infra instablion, by served and number) Fallstom General Hospital 5. Social Security Number 216-05-4882 | | 1. Decedent's Nar | ne (First, Middle, | Last) | | | | | | 2. Dete of Dec | eth | | 3. Time of De |
| Second Security Number Center all Hospital Security Number Center Cen | | Erma Ka | therine | Nortrup | | | | | | Amonth | 1/ | _ | 12:50 |
| 8. Social Society Number 216-05-4882 | ŀ | | | | | | | 4 | 4b. City, Town, or I | ocation of Death | | - | |
| 216-05-4882 I | Ì | Fallsto | m Genera | 1 Hospi | | | | | | on | На | rfo | rd |
| 20-05-4882 10 m 2sr 80 7rs April 8, 1919 Maryland 10s. Conty 10s. City, Town or Location 10s. Site 10s. Conty 10s. City, Town or Location 10s. Site 10s. Conty 10s. City 10s. City, Town or Location 10s. Site 10s. City 10s. | | | | 6. Sex | | s. last birth | | | | | h Venel | 9. Bir | thplece (Stete or Fo |
| to. Street and Number 1000 Whee I Road 10. Zep Code 21015 10. Separation of Whee Country? 1000 Whee I Road 11. Was Dependent Ever in U.S. 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Martial Salus 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Was Dependent of Hispanic Crigin' (Septicy Yas or No- 11. Rear Annation Index, 11. Rear Annation Index, 11. Rear Annation Index, 12. Rear Annation Index, 13. Rear Annation Index, 14. Rear Annation Index, 15. Dependent of Hispanic Crigin' (Septicy) 16. Do Rear Index, 16. Rear Annation Index, 17. Father's Name (Frat, Middle, Malden Summer) 18. Mother's Name (Frat, Middle, Malden Summer) 19. Mother's Name (Frat, Middle, Malden | | | | 1□ M 2ØF | | | | | | | | | |
| 11. Marial Status 12. Was Decedant Ever in U.S. 13. Wes Decedant Ever in U.S. 14. Marial Status 15. Decedant's Education 15. Decedant's Education (Specify Only highest grade completed) 15. Decedant's Education (Specify Only highest grade completed) 15. Decedant's Education (Specify only highest grade completed) 16. Decedant's Education (Specify Only highest grade completed) 17. Fartar's Name (First, Middle, Last) 18. Mariar's Name (First, Middle, Last) 19. Informatic Name/Representation (First, Middle, Last) 19. Mailing Address (Sirest and Number or First) 19. Mailing Address (Sirest and Number | | | | ord | | | | | | | | | 10d. Inside City L |
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| 18e Decoder's Busines Sinder Sussessindustry 16e Nind of Businessindustry 16e Nind of B | | 1 Never Mar | Armed I | Forces? s 2 🖾 No Give | U,S. | | | | pecify Yas or No- o Rican, etc.) | Bla | ick, Whi | ite, etc. | |
| Elementary/Secondary (0-12) 17. Fabre's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Summer) 19. Informent's Name/Feletionship (Type, Print) 19b. Informent's Name/Feletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Wheel Road Bel Air , Maryland 21015 20b. Pilece of Disposition 1000 Wheel Road Bel Air , Maryland 21015 20b. Pilece of Disposition (Name of Library) 1000 Wheel Road Bel Air , Maryland 21015 20b. Pilece of Disposition (Name of Library) 20b. Pilece of Disposition (Name of Library) 21. Signature of Emeral Service Library (Common of Order pilece) Parkwood Cemetery 22. Name and Address of Facility 23b. Poth—Salar the Stassas, or Commission fine that caused the death. Do not enter the mode of dying, such es cardiac or respiratory areast. 1000 1000 Wheel Road Bel Air , Maryland 21015 21. Signature of Emeral Service Library (Common of Order pilece) 22b. Name and Address of Facility 22c. Name and A | - | (Spe | | Education | | 18e. C | Decedent's Usua (Give kind of wo | el Occup | ation during most of wor | king | 16b. Kind of B | Business | s/Industry |
| 18. Mother's Name (First, Middle, Maiden Summer) | | | ondary (0-12) | College | (1-4or 5+) | | | | | | D 11- | | |
| Albert A. Neutze 19e. Informent's NemerRelationship (Type, Print) Jerry A. Neutze 20e. Method of Disposition 18 Neutze 20e. Method of Disposition 19 Neutze 20e. Method of Disposition 19 Dete 20e. Location - City or Town, Stele, Zip Code) 21 Signature of Deneral Service Libensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name of Address of Facility 25. Name and Address of Facility 26. Place of Deseth 10 Neutze 27. Name of Address of Facility 28. Disposition 29 Due to (or as a consequence of): 29 Due to (or as a consequence of): 20 Due to (or as a consequence of): 20 Due to (or as a consequence of): 21 Due to (or as a consequence of): 22 Due to (or as a consequence of): 23 Due to (or as a consequence of): 24 Due to (or as a consequence of): 25 West case referred to innectal examinant in medical examinant in medic | | | (First Middle 1 | act) | | Fac | ctory Wo | orke | | no (First Middle | | | |
| 196. Informent's Neme/Reletionship (Type, Print) 196. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Wheel Road Bel Air , Maryland 21015 206. Method Disposition 1X78 unit 2 20cmants | | | | | | | | | | | | mej | |
| Jerry A. Neutze 1000 Wheel Road Bel Air , Maryland 21015 | - | | | | | 105 | Mailine Address | (Street | | | | Ctota | Zin Codel |
| Commercial 2 Coremetion 3 Removal from State Parkwood Cemetery 4/19/99 Baltimore, Mary | | | | p (Type, Print) | | | | | | | | | |
| 21. Signature of Evidental Service Libranee 22. Name end Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Petr. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Interest Entered Interest | 1 | | • | 3 □Removal from | | . Piece of C | Disposition (Nen | ne of other piec | ce) | Date | | - City or | Town, Stete |
| 23a. Pertra-saler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse on each line. Approximination of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse on each line. Approximination of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse on each line. Approximination of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only an acuse of the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only and acuse of the mode of dying, such as cardiac or respiretory errest, shock and shock or heart failure. List only and acuse on each line. Approximination of the mode of dying, such as cardiac or respiretory errest, shock and acuse of the mode of dying, such as cardiac or respiretory errest, shock and acuse of the mode of dying, such as cardiac or respiretory errest, shock and acuse of the mode of dying, such as cardiac or respiretory errest, shock and acuse of the mode of the mod | - | 4 Denotion | | | 11 State | | | | | 1 110 100 | | | |
| Ceuse (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): d. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause 1 24e. Was an autopsy performed? 24e. Was an autopsy performed? 25. Wes case releared modical examiner? 1 Yes 2 No No Yes | | 21. Signature of Factor Shock, or he disasse or conditions and the course disasse disa | the disease, or deer failure. List on | censee | t caused the de | eath. Do no | 22. Name en 6415 Be ot enter the mod | eter nd Addre elai de of dyin | ss of Facility Jor Road Bong, such es cardiad | ohn C. Maltimore | iller I , Maryl | Inc. | |
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| 24b. Were autops available price completion of deeth? 25. Wes case referred to medical examiner? 1 Yes 2 No 1 Yes 2 26. Plece of Deeth (Check only one) 1 Yes 2 27. Manney of Deeth 1 Matural 2 See. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury of Nort? 28c. Injury of Nort? 28d. Describe how injury occurred Work? 28d. Location (Street end Number or Rurel Route Not City or Town, Stete) | 1 | 23a. Pertt. Saler shock, or he limmediete Ceuse disaese or condition resulting in deeth) Sequentieily list configuration in the sale shock of the sale shoc | the disease, or der failure. List of the disease, or der failure. List of the disease, or der failure. List of the disease, or | consecutions that a | t caused the deleach line. | o (or es e co | 22. Name en 6415 Be ot enter the mod onsequence of): | eter nd Addre elai de of dyin | r Road B. ng, such es cardiac | ohn C. Maltimore correspiretory ar | iller I , Maryl rest, WCEV | Inc. | 21206 Approximate Interval Between Onset and Dee |
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| 2 Accident 3 Suicida 4 Homicide M 1 Yes 2 No See Piece of Injury - At home, farm, street, factory, office 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route No. City or Town, Stefe) | | 23a. Pert: Saler shock, or he immediate Ceuse disasse or condition resulting in deeth) Sequentially list or if any, leading to include a ceuse. Enter Under Ceuse (Disasse or that initiated event resulting in death) Pert II. Other significant ceuses are significant ceuse. The ceuse (Disasse or that initiated event resulting in death) | the disease, or deritaliure. List of the disease diseas | b d Hospital: | t caused the deleach line. EAS Due to Due to | o (or es e co | 22. Name en 6415 Be ot enter the mod 77 Consequence of): | eter nd Addre elai de of dyin | r Road B. R | 23b. Did 1 24a. Was perfo | iller I , Maryl rest, SCEV cobacco uss co Yes 20 No an autopsy med? (es 20 No | Inc. Land Optribut 3 1 | 21206 Approximate Intervel Betwee Onset and Dee Dee Onset and Dee Onset |
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| 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. | | 23a. Pert. Sater shock, or he immediate Ceuse disaese or condition resulting in death) Sequentially list or if any, leading to icause. Enter Und. Ceuse (Disaese othat initiated even rasulting in daath) Pert II. Other significant in the ceuse of the c | the disease, or derivative. List of the disease, or derivative. List of the disease, or derivative. List of the disease, or di | b b c d Hospital: | t caused the de each line. Due to Due to Dua to death but not a death but not | o (or es e co | 22. Name en 6415 Be ot enter the mod onsequence of): onsequence of): the underlying of patient 3 Do oime of jury | eter nd Addre elai de of dyin Base Injur Wor | r Road B. r Road B. rg, such es cardiac REAS S ren in Pert I. | 23b. Did 1 24a. Was perfo | iller I , Maryl rest, CEV Cobacco use co Yes 20 No an autopsy med? (es 20 No | Inc. Land Optribut 3 1 24b. | 21206 Approximate Intervel Betwee Onset and Dee Dee Onset and Dee Onset |
| (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. | | 23a. Perti-Saler shock, or he Immediete Ceuse disasse or condition resulting in deeth) Sequentielly list or if any, leading to icause. Enter Und Ceuse (Disasse of that initiated event rasulting in death) Pert II. Other significant in the condition of the cond | the disease, or deritaliure. List of the disease, or deritaliure. List of the disease, or deritaliure. List of the disease, or | b. d. Hospital: Contributing to 28e. Detection of the contribution of the contribu | t caused the deleach line. The Source of Injury anth, Dey Year) | ceath. Do not be ath. Do not be ath. Do not be ath. Do not be at a configuration of the ather | 22. Name en 6415 Be of enter the modern of sequence of | eter nd Addre elai de of dyin DA Oth Case Injur Wor 1 | r Road B. r Road B. rg, such es cardiac REAS S ren in Pert I. | 23b. Did 1 24a. Was performent of the Check only of the Check onl | iller I , Maryl rest, COV cobacco use co Yes 2 No an autopsy med? Yes 2 No cove) dence 6 Ot now injury occu | Inc. Land 2 optribut 3 F | 21206 Approximete Intervel Betwee Onset and Dee Dee Onset and Dee Onset |
| 29c. Licansa number 29d. Data signed (Month, Day, Year | | 23a. Perti-Saler shock, or he immediete Ceuse disaese or condition resulting in deeth. Sequentieily list configuration in deeth. Pert II. Other signification in deeth. 25. Wes case reference examiner? 1 Yes 21 27. Manner of Deeth. 28. Certifier (Check only) | the disease, or dert failure. List of the disease di | b. d. Hospital: 28e. Date (Mc Physician: To the | Due to | Death. Do not be a control of the co | 22. Name en 6415 Be ot enter the mod consequence of): onsequence of): the underlying consequence of patient 3 DC ime of jury M m, street, factory | eter Ind Addre elai Ge of dyin Base. Injur Wor 1 1 y, office | r Road B. rg, such es cardiad REAS ren in Pert I. 26. Piece of Declar: 4 Nursing Hyel ren, date and place | 23b. Did 1 24a. Was performent of the Check only of the Check onl | iller I , Maryl rest, NOCOV NOBACCO USS CO Yes 20 No an autopsy rmed? Yes 20 No an autopsy rmed? Yes 20 No an autopsy rmed? Yes 20 No an autopsy rmed? | optribut 3 24b. | 21206 Approximate Intervel Betwee Onset and Dee Onset and |

State Registrar

31. Date filed (Month, Day Year) 2 1 1999 32. Registrer's Signeture



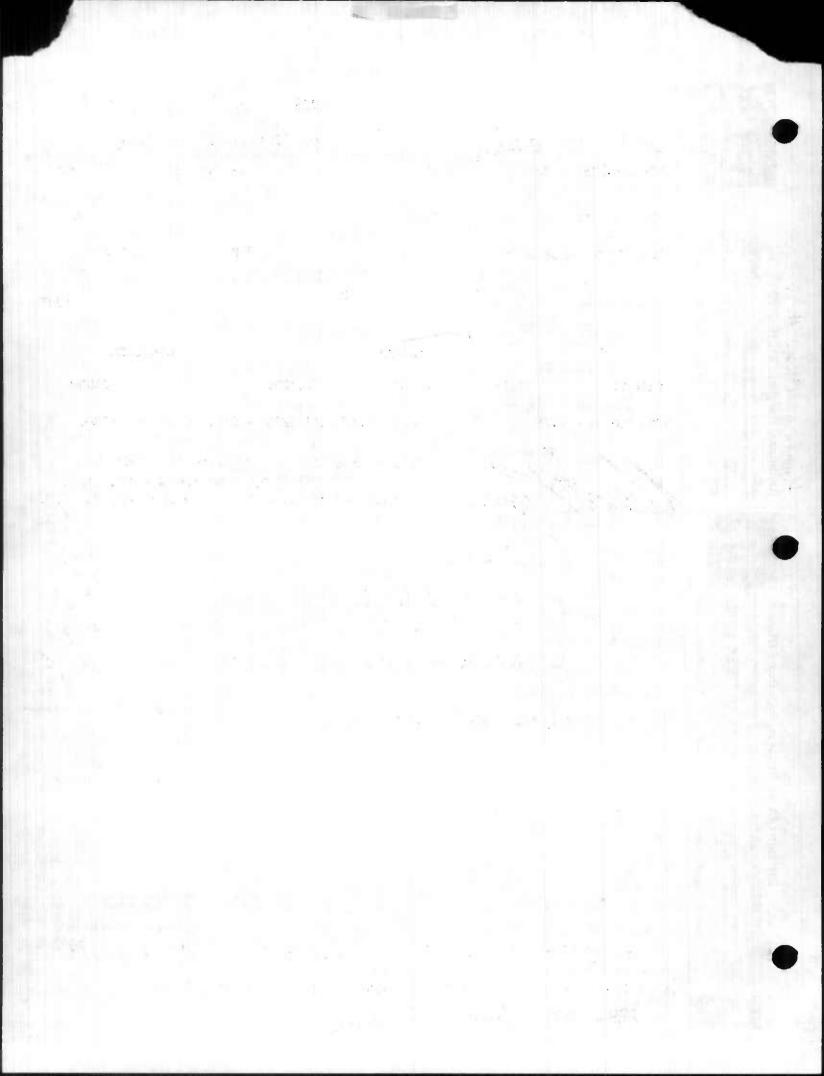
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** 2:24 MOSES PREIS /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and nymber) 4c. County of Death Examiner 6. Sex Baltimore mai if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) if Under 1 Year 9. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 1 € M 2 □ F Days 082-28-5183 84 Yrs. POLAND MAY 15,1914 Director Usual Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at the Maryle MD N/A BALTIMORE 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3501 SEVEN MILE LANE 21208 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarlo Ricen, etc.) 14 Race - American Indian Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Department of Health and Mental Hygiena. important: if Item 27 is marked other than Elamantary/Secondary (0-12) Collage (1-4or 5+) CANTOR RELIGION 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) ARYEH PREIS MINDEL KARSH SHLOMO 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 3501 SEVEN MILE LANE - BALTIMORE, MD ROSA PREIS / WIFE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 3 Kinemoval from State 9 □ Cremation eny injury 4 DDo Other (Specify) HEBRON CEMETERY 4/19/99 FLUSHING, NY 22. Nama end Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 has that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each lina. Approximata Interval Between Onsat and Death Physician /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequanca of): Examiner perforation physician and the burial-transit Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disaasa or injury the deeth certificeta be exec necrosis Physician/Medical the that initiated events resulting in death) Last SE ocardial infaction 980 ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the detached 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificete has 1 Yes 2 XNo 1 ☐ Yes 2 NoNo director, 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 200 No 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA Aftar this funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Ne Hospital or Attending Pin 24 hours after death. Certification: 1 Naturat 5 ☐ Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Cartifian 1 Certifying Physician: To tha best of my knowladga, daath occurred at the tima, date and place, and due to the cause(s) and mannar as statad. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Within 2 To the 29b. Signature and title of partifiar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print) Dawn Dillman Ewh Baltmore, MD 21215 MD 2701 W. Belvedere 32 Registrar's Signatura 31. Data filed (Month, Day, Year) State APR 2 0 1999 Registrar

Division of Vital Records, P.O. Box 68760.

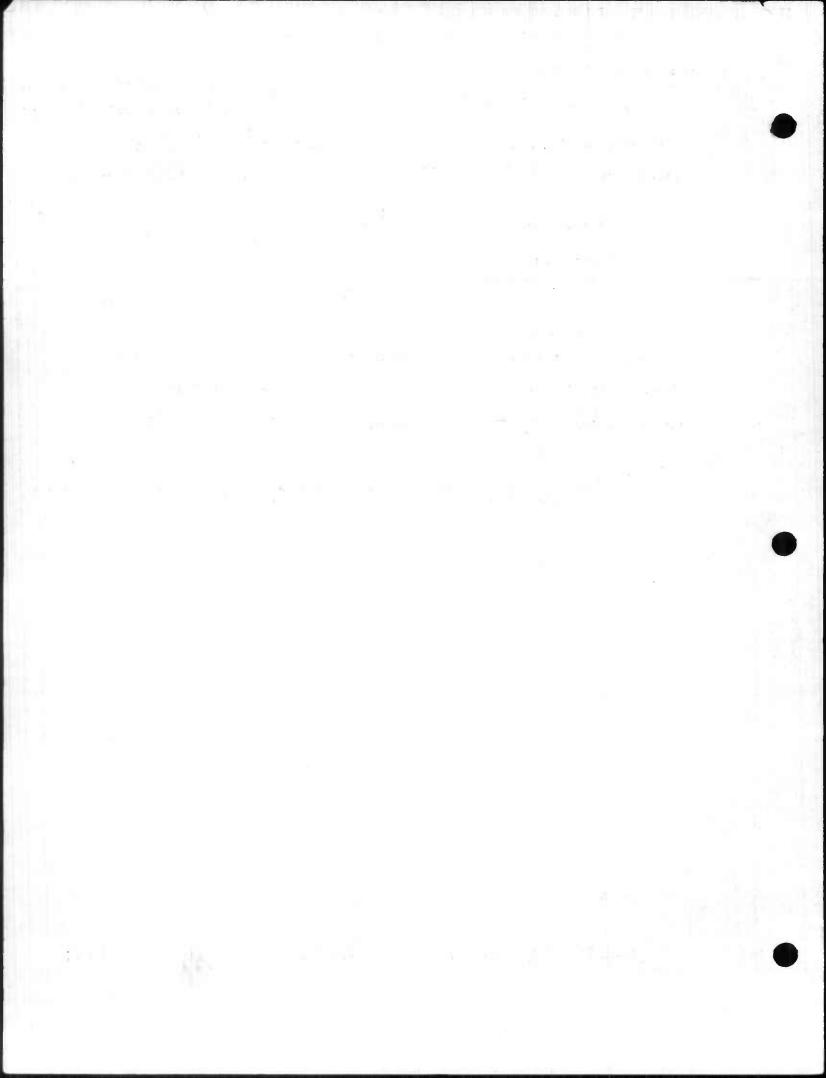
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DHMH 16 Ray 6/95



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| Ite | m 1 | 8 Per AB FilmG770 4- | 20-99 rja | ai yiaii | | ficate of | Death | | Reg. No. | | 301.6 | |
|---|----------------|--|--|--|---|-------------------------------------|--|--|---|-----------------------------|--|--|
| Physici /Medi | | 1. Decedent's Name (First, Middle, Emily M. | Pac Pac | е | | | | 2. Date of Dea Month April | Dey | Yeer 999 | 3. Time of Deeth 12:20 pm | |
| Examir | | 4a. Facility Neme (If not institution, | give street and number) | | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | |
| | | Friends Nursi | | | | | Sandy Spr | ings | Montg | omery | 7 | |
| Funeral Director | | 5. Social Security Number 214-24-9945 Usual Residence of Decedent | 5. Sex 1 ☐ M 2 🛣 F | je (In yrs. I | . last birthday) If Under 1 Yes 99 Yrs. Months Day | | | 8. Date of Birt (Month, Day August | h y, Year) 31,1899 | 9. Birthol Count Mary | ace (State or Foreign ry) Land | |
| r 28a-f ahow | ž | 10a. Stete 10b. County | | | , Town or Local | NG | | | | 10 | od. Inside City Limits | |
| the M | Director | Maryland Montgo | mery | Sar | idy S pri | 10f. Zip Code | | | 10- 04 | D-11 Co-11 | 131111 | |
| with a | ā | | 1 | | | - /2, - 2-20 | 860 | | 10g. Citizen of V | | ryr | |
| eath w | era | 17401 Norwood R | 12. Wes Decedent | Ever in U. | S. 13. Wa | | | ecify Yes or No- | U.S. | A America | n Indien. | |
| 020 urs aftar dea ur, or items | by Funeral | 1 □ Never Merried 2 □ Marrie | Armed Forces? | Armed Forces? If Yes, specify (1 Yes 2 No If Yes, Give 1 Yes | | | | Rican, etc.) | Biac Specify | k, White, e | itc. | |
| Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiena. 7 Is mericed other than "natural", or items 23a or 28a-f show traumatic event, tra Medical Examina must be notified at | Be Completed | 15. Decedent's (Specify only highest Elementery/Secondery (0-12) | Education grade completed) College (1-4or: | 5+) | 16a. Deceden (Give kin life. DO | | pation during most of work d) | king | 16b. Kind of Bu | | uatry | |
| other vent, | Ö | 17. Fether's Neme (First, Middle, L. | | | TIULES | 301 | 18 Mother's Nem | e (First, Middle, | | | | |
| Maryland d2 should be filed th and Mental Hy 7 is marked othe traumatic event, | To B | Thomas Kelso Mu | ller | | | | May Mae Lou | | | | | |
| shou nd M | _ | 19a. Informant's Name/Reletionshi | | | 19b. Malling | Address (Street | end Number or Rui | | | Stete, Zip | Code) | |
| 2 2 21 4 | | unknown CAMILLA M | cROY / ATTORNI | Υ | -unknov | yn 414 | HUNGERFORD | DR. #458 | ROCKVILL | E, MD. | 20850 | |
| Baltimore, M emit. Pagas 1 and 2 bepartment of Haalth a mportant: if item 27 is my injury or other tra ings. | | 20a. Method of Disposition 1 ☐ Burlet 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spe | | 20b. P | lece of Dispositi emetery, cremat | on (Name of lory or other pla | ice) | Dete | 20c. Location - | City or To | wn, State | |
| Baltimo pemit. Pagas Departmant of Important: If I any Injury or page. | | 21. Signature of Funeral Service Li Ronald | S. Wade, Di | | ess of Facility tomy Boar , Marylan | | | more | Street | | | |
| Physician | | 23a. Part 1. Enter the disease, of c shock, or heart failure. List of | omplications that cause nly one cause on eech li | d the death ne. | n. Do not enter t | the mode of dy | ng, such as cardiac | or respiratory ar | | 8 1 | Approximete Interval Between Onset and Death | |
| /Medical Examiner | er | Immediate Cause (Finel disease or condition resulting in death) | o. Corn | Due to (o | r as a conseque | ndi W | infai | rction | | 5 | minuks | |
| 68760, ficate be axecuted physician and is the burial-transit | al Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | b. COV UY | Due to (or | nas a conseque | nce of): | arceas | <u>ę</u> | | | U years | |
| U = 0.1 | n/Medical | thet initiated events resulting in death) Last | d. | Due to (or | as a consequen | nce of): | | | | | | |
| o daat tha attr | sicie | Part II. Other significant condition | contributing to death b | ut not resu | ulting In the unde | rtying cause gi | ven in Part I. | 23b. Did 1 | lobacco uee cor | tribute to | the cause of death? | |
| d by | by Physician/M | | | | | | | 10 | Y●● 2 □ No | 3 Prob | ably 4 Unknown | |
| 2 s t | Completed | | | | | | | 24e. Was perfo | en autopsy rmed? | ava | re autopsy findings illable prior to apletion of cause leath? | |
| The in | Con | | | | | | | 101 | res 25 No | 1 🗆 | Yes 2□ No | |
| r VITAL Program: The ysician: The director, pag | Be (| 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | th (Check only o | ne) | | | |
| Of VIta Physician: this carific ral director, | 10 | 1 Yes 2 No | | | ER/Outpatient | 3LI DUA | | ome 5 Resid | dence 6 Othe | er (Specify |) | |
| UNISION OF Or Attending Phater death. Director: After this | | 27. Manner of Deeth 1 Panaturel 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 N | | | | | | 28d. Describe how injury occurred | | | | |
| DIVISION To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the tuneral | Certification: | 3 Sulcide 6 Could no 4 Homicide determin | ed 286. Place of in | 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route N City or Town, State) | | | |
| he Hosp in 24 hou he Funei plataly fil | edical | 29a. Certifier 12 Certifying (Check only one) 2 Medical Ex | Physician: To the best caminer: On the besis o and manner st | examinat | vledge, death or ion and/or inves | curred at the fi tigetion, in my | me, dete and place, opini <i>on</i> , death occur | and due to the cred at the time, | cause(s) and ma date and plece, a | nner as st and due to | eted. the cause(s) | |
| With To th | Σ | 29b. Signature and title of certifier | 1 | | | 29c, Licen | se number | | 29d. Date signed | (Month, L | Dey, Year) | |
| | | On M. | th | | 2 | D23 | 124 | C | Doril 1 | 5.1 | 999 | |
| | | 30. Name and address of person w | 40 | leath (Item | 23a) (Type, Pri | ola | alwood | ct | Olm | 7 | 999 no 2083. | |
| Sta Registr | | 31. Date filed (Month, Day, Year) ADD 9 0 1999 | 32. Registr | | ture | 100 | | • | | L | , | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day April 8, 1999 5:20 am Laura 0. Prall 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Homewood Retirement Nursing Center Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1□M 25 F Months Days 95 24, 1904 South Dakota 217-32-6453 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location t0d. Inside City Limits 1 ☐ Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 W. Patrick Street 21701 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working tife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Professor Hood College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thaddeus Prall Laura Bowie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2135 Pennsylvania Ave., St. Albans, W.VA. 25177 Scott Scobell/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signalare of Funeral Service Licensee 22. Name end Address of Facility Ronald S Director State Anatomy Board, 655 W. Baltimore Street. Baltimore, Maryland 21201 art. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LAYSH Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 40 3 Probably 4 Unknown Alzheimr 24b. Were autopay findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 No 25. Was cese referred to medicet examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

p

Completed

Funeral

Director

7 is marked other than "naturs!", or items 23a or 28a-f show traumetic event, the Medical Examination notified at

permit. Pages 1 and 2 should be filed within 72 hours effer 1 Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Wed call Examinat 0069.

Baltimore, Maryland 21215-0020

with the Marylend

death

physician and the buriel-transit certificete be axecuted use as 0 the been signed by should be detac has

Box 68760.

P.O.

Division of Vital Records,

Examiner Physician/Medical aftar death.

Director: After this certific funeral director,

by Completed Be Certification: To

3 Suicide 4 Homicide 29a. Certifier (Check only one)

Maturat

2 Accident

6 Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person

29c. License number 109689 29d. Date signed (Month, Day, Year) 15

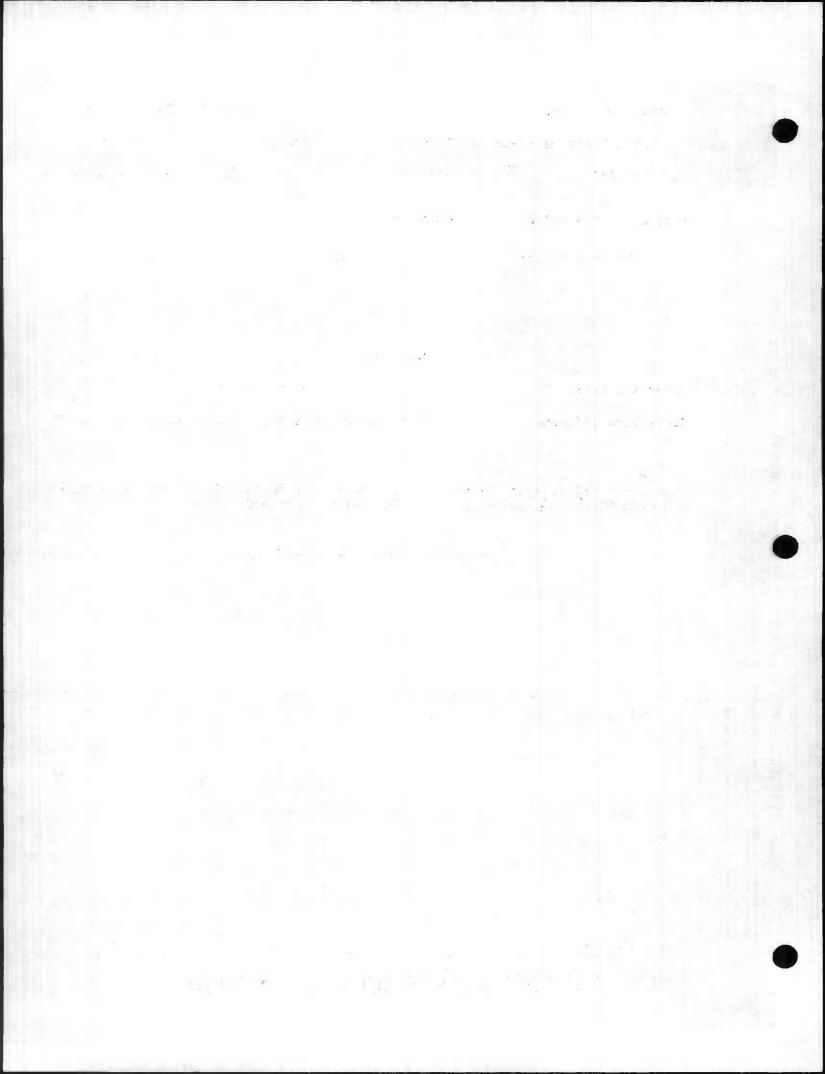
State Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 0 1999 32 Registrar's Signature merca

24 hours a

To the Within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | | | | ificate of | | d Mental H | Reg. No. | | 3048 | |
|---|---------------------|---|--|--------------------|---|--|---|--|---|------------------------------------|---|--|
| hysicia /Medic | | 1. Decedent's Name (First, Middle, Marjorie Eliz | abeth Pl | itt | | | | 2. Dete of Month 04 | Dey | Year 999 | 3. Time of Deat 3:00 pm | |
| xamin | | 4a. Facility Neme (If not institution, | give street end numl | ber) | | | | or Location of De | | | | |
| | | Broadmead 5. Sociel Sacurity Number 6 | S. Sax 7 | . Aga (In yrs. las | et hirthday) | If Under 1 Yaar | Cockey | | | | | |
| neral ector | | 072-18-4396 Usuai Residence of Decedant | 1□M 2⊋F | 75 | Yrs. | Months Deys | | fin. 8. Date of I (Month, 11/2) | Dey, Year) 6/23 | Coun | laca (Stete or Fore try) Ohio | |
| 111 | | 10a. State 10b. County | | 10c. City, | Town or Loca | ation | | | | 10 | 0d. inside City Lin | |
| Ded | to | Md. Balti | more | Co | ckeysv | 111e | | | | | 1 ☐ Yes 2 🔀 | |
| 5 | rec | 10e. Street end Number | | | chej ov | 10f. Zip Code | | | 10g. Citizen of | of What Country? | | |
| 4 | alD | 13801 York Road | | | | 21030 | | | USA | | | |
| other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 1 Never Marriad 2 Married if Yes 22 No if Yes, Give 1 | | | | | lispanic Origin? en, Mexicen, Pu Specify: | (Specify Yas or justice Ricen, etc.) | Ble | ce - America ck, White, ov. Whi | etc. | |
| al Ex | D D | 3 ☐ Widowed 4 🗖 Divorced | Yeer or Date | | 10- 01 | | Cart . | | | | | |
| the Medic | Completed | 15. Decedant's (Specify only highest Elemantary/Secondary (0-12) 12 years | | lor 5+) | (Giva ki | nt's Usuel Occup ind of work done O NOT use retired brarian | during most of | working | 16b. Kind of B | usiness/Ind | lustry | |
| ent, | BeC | 17. Fether's Neme (First, Middle, La | | | | nrarran | 18. Mother's i | Nama (First, Midd | lle, Maidan Suman | ne) | | |
| tic e | ToB | Frederick Lent | Z | | | | Jose | phine Co | urt | | | |
| amna amna | | 19e. informent's Neme/Ralationship | (Type, Print) | | 19b. Mailing | Address (Straat | and Number or | Rural Routa Nun | ber, City or Town | State, Zip | Code) | |
| any Injury or other tra | | Deborah Anderso 20e. Method of Disposition 1 Burial 2 Cremetion 3 | | 20b. Plac | CA Of DISDOSI | nsington | | verna Pk | Maryland 20c. Location | 1 211 | 46 wn, Stete | |
| jury | | 4 □ Donation 5 🖔 Othar (Spe | cify) | | atomy | Board | | <u> </u> | Maryla | and | | |
| any In | | 21. Signeture Furnyai Service Licensae 22. Name and State An | | | | | | rd,655W. | Baltimor | eSt,M | D21201 | |
| as the bur | fedical Examiner | Immediate Ceuse (Finei disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Undarlying Ceuse (Disease or injury that initieted events resulting in deeth) Last | e | Due to (or a | JEU es e conseque s e conseque es e conseque | D ance of): | A | | | | Solver end Death 5 doys | |
| od for use as | Physician/M | Pert II. Other significent conditions | d | th but not resulti | ing in the ung | arlying cause giv | en in Pert i | 23h Di | d tobacco usa of | ntribute to | the cause of des | |
| | by Phys | | | | | | | | Yes 2D No | | ebly 4 Unkn | |
| 2 should | ompleted | | | | | | | 24a. We pe | es en eutopsy rformed? | ava | ra eutopsy finding illabia prior to nplation of causa leath? | |
| 0 (| ပ | | | | | | | 10 | Yes 2 No | 1□ | Yes 2□No | |
| 90 | o Be | 25. Wes casa referred to medical axaminer? | Hospital: | | | oth Oth | or / | Deeth (Check onl | | | | |
| · I | ⊢⊦ | 1 Yas 2 No 27. Manner of Death | 1 ☐ Inp | | R/Outpetient 8b. Tima of | 3□ DOA 28c. injur Wor | 4 LLT NUTSIN | 7 | sidence 6 Oth | |) | |
| completely filled in by the funer | Certification: | 1 DN atural 5 Pending Investigat 3 Suicide 4 Homicida | k? Yes 2□No | | | | | | | | | |
| taly fill | edical C | 29a. Certifiar (Check only one) 12 Cartifying 1 2 Medical Ex | Physician: To the basi aminer: On the basi end menne | s of examination | edga, daath o n and/or inva | occurred et tha tin stigation, in my o | na, data and ple plnion, daeth o | eca, end due to the courred at the time | e ceusa(s) and me e, dete end plece, | enner es sto end due to | etad. the causa(s) | |
| eldmoo | Me | 29b. Signature and title of certifiar Barba | a Ca | rrole | Lim, | 29c. Licens | e number 3839 | 72 | 29d. Date signe | d (Month, L | Day, Year) | |
| | | 30. Neme end eddrass of person wh | o completed ceusa | of daath (item 2 | 3a/ (Type, Pi | int) | 1 | | OCKEY | | 1 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Eleanor T. . Rhoades 19 1999 April 4:00 A.M. 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 8. Data of Birth (Month, Day, Yaar) Oct. 6, 19 If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) 9. Birthplace (Stata or Foraign 10 M XX F Months Deys Hours 210 16 5839 74 Yrs. 1924 Pennsylvania Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 12 No Maryland Prince George's Largo 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 10100 Campus Way S. #204 20774 United States 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 22 No If Yas, Giva Year or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Never Merried XIX Married 1 Yas 2X No Specify: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Department of Defense Statistical Clerk 12 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fether's Neme (First, Middle, Last) Minnie Bannister Carl Andrews 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 10606 Narrow Leaf Court Largo Maryland 20774 Antoinette Proctor Daughter 20b. Place of Disposition (Nama of camatary, cramatory or other place) April 23 at 199920c. Location - City or Town, Stete 20a. Mathod of Disposition Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Lakemont Memorial Gardens Davidsonville MD 21. Signature of Funeral Sarvice Licansaa 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete tritarval Batween Onset end Deeth Advanced Netastalie Evolometrial Carcinona. tmmediata Causa (Final disaase or condition rasulting in daath) Dua to (or as a consequence of): Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings evailable prior to complation of cause of death? Hypertessin 24a. Wes an eutopsy performed?

Physician /Medical Examiner

The law requires that the death cartificate be axecuted

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this cartifica

funaral

the Funeral Director of the Fu

To the Hosp within 24 hor To the Fune completaly fi

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

p

Completed

Funeral

Director

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, in Medical Example must be notified at once.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury Physician/Medical that initieted avents rasulting in daath) Last 85 usa signed by the a à Completed cartificata has t director, paga 2 s

Be

Certification: To

Medical

1 Yas 2 No

26. Piece of Deeth (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

1 ☐ Yas 2 ☐ No

25. Was case referred to medical axeminer? 1 Yas 2 No 27. Manner of Death

1 Natural 2 Accidant

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Data of Injury (Month, Day Year) 5 Pending invastigation

Hospitel:

1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify)

28c. tnjury et Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

1 A Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piaca, and dua to the cause(s) end menner as stated.

2 Madical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, deta end piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

otord MD ananak

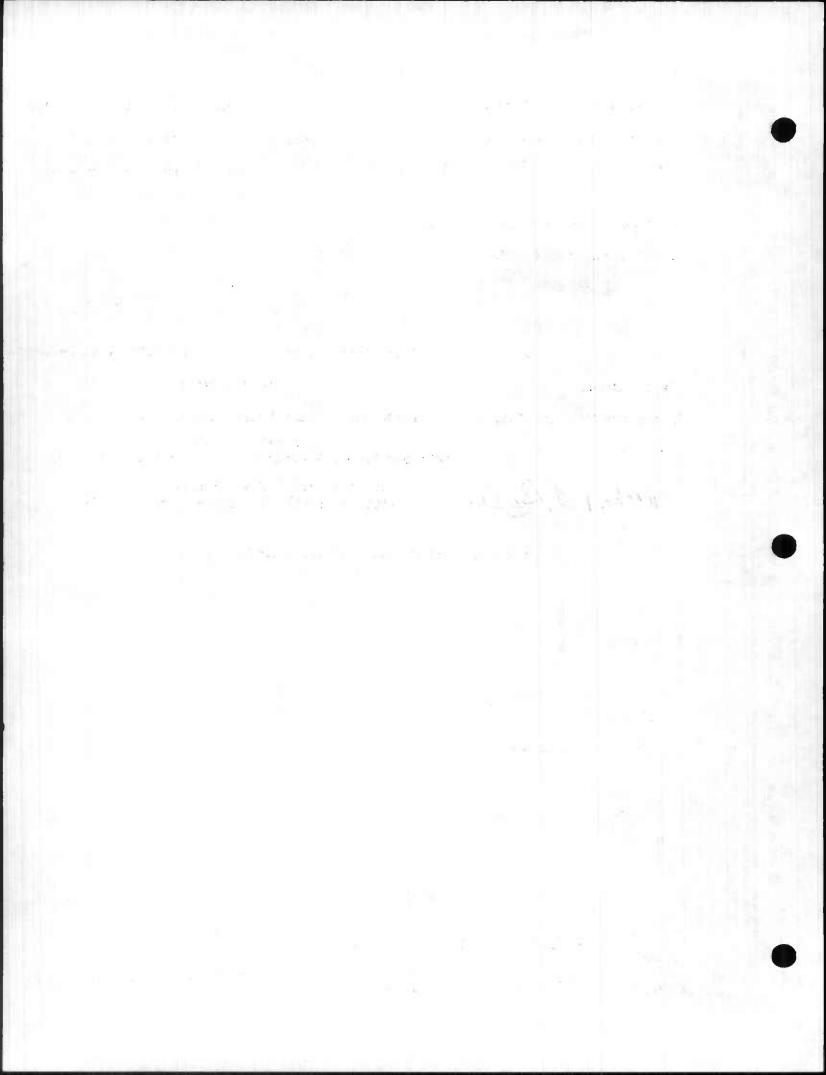
31. Deta filed (Month, Day, Year) APR 2 1 1999

6 Could not be

32. Registrar's Signature

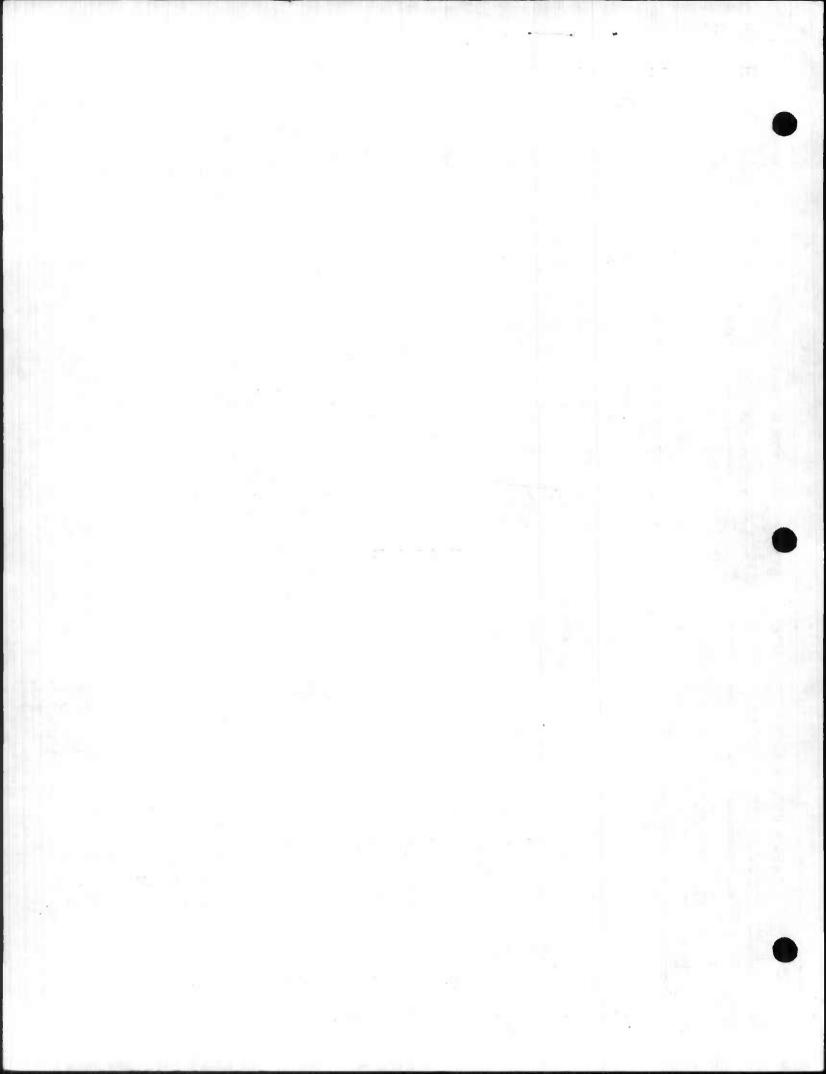
Greenway Center Dr. = 209 Greenbett MD

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| ician | PART I, 27, 28A- | F PER MEO G7 | 70 4-23-9 | 9 WR. Cer | tificate of | Death | 2. Date of | riog. Ivo. | 9 | 3 U 5 U |
|--------------------------|--|--|--|--|--|---------------------------------|--|--|---|---|
| | NINA ROB | | | | | | Month APRII | Dey | Year 999 | 1933 PM |
| dical niner | 4a Facility Name (If not instituted 109 WHEELER | ution, give street and | number) | | | | n, or Location of D | | 000 | 1933 FM |
| ıl e | 5. Social Security Number | 6. Sex | 7 Age (In v | rs. last birthday) | If Under 1 Year | | 4 Hrs. 8 Date of | Birth | 9 Rirthol | ace (State or Foreig |
| | 213-64-7353 | 1□ M 20X 8 | | | Months Days | Hours | Min. (Month, | Day, Year) 2/1955 | Count | ace (Stete or Forei ry) • |
| | Usual Residence of Decedent 10a. Stete 10b. Cou | | 10c. | City, Town or Lo | cation | | | | 10 | d. Inside City Limit |
| 50 | MD. | , | | | | | | | | 1 X Yes 2 □ N |
| Funeral Director | 10a. Street and Number | | | BALTIMOR | 10f. Zip Code | | | 10g. Citizen of | What Count | ry? |
| 5 | 1111 PARK AV | E. APT. 50 | 08 | | 21201 | | | USA. | | |
| 1 | 11. Marital Status | Armed | ecedent Ever in Forces? | U,S. 13. \ | Was Decedent of Yes, specify Cul | Hispanic Origi ban, Mexican, | in? (Specify Yes or Puerto Rican, etc.) | | ce - America ick, White, e | |
| | 1 ☑ Never Married 2 ☐ I 3 ☐ Widowed 4 ☐ Divor | if Yes, | es 2 🖾 No Give er Dates: | 1 | I□Yes 2⊠No | Specify: | | Specia | BLAC | K |
| | | dent's Education ghest grade complete | ed) | (Give | lent's Usuet Occu | during most | of working | 16b. Kind of B | | |
| | Elementery/Secondery (0-1 | 2) College | e (1-4or 5+) | life. L | DO NOT use retin | 9d) | | | | |
| Population a | 12 17. Father's Neme (First, Mide | die, Last) | | NUR | SE (RN) | 18. Mother | 's Neme (First, Mid | HOSPIT | | MERCY) |
| 10 26 | JAMES C. ROB | ERTS | | | | NAN | NIE ROBE | RTS | | |
| | 19e. Informent's Neme/Retet | ionship (Type, Print) | | 19b. Meilin | ng Address (Stree | | | mber, City or Town | , State, Zip | Code) |
| | DONTE MORRIS | | loos | 1627 b. Place of Dispo | | R GROVE | | RE, MD. 2 | | - 61-11 |
| В | 20a. Method of Disposition | | | cemetery, cren | netory or other pla | ace) | Date | 20c. Location | | |
| any injury or | 4 Donation 5 Othe 21 Signature of Funeral Serv | | | KINGS P | | ess of Fecility | 4/16/99 | 9 BALTIM | ORE M | U. HOME D A |
| | D. Call | 51 | | | 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL 1300 EUTAW PLACE BALTIMORE MARYLAND 21 | | | | | |
| Examiner | Immediate Cause (Finel disease or condition resulting in deeth) | a | | C INTOXIC | | | | | 1 1 1 | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last | c | | o (or as a conseq | | | | | | |
| Physician/Me | Pert II. Other significant cond | ditions contributing to | o death but not | resulting in the ur | nderlying cause g | iven in Part I. | 23b. 8 | Did tobecco use co | ontribute to | the cause of deat |
| | | | | | | | 1 | Yea 2 No | 3 Prob | ebly 4 Tunkno |
| completed by | | | | | | | 24a. V | Vas an autopsy erformed? | con | re autopsy findings ilable prior to apletion of cause leeth? |
| Con | | | | | | | 1 | Yes 2 No | 15 | Yes 2□ No |
| ni director To Be | 25. Wes case referred to med examiner? | Hospital: | | | | | of Deeth (Check or | | | |
| | Yes 2 No 27. Menner of Deeth 1 Neturet 5 Per | 28a. De | Inpatient 2 ete of Injury fonth, Day Year d: 4-10-99 | 28b. Time of Injury | P 28c. Inj | 4 LI NUE | 28d. Descr | Residence 6 Dot ibe how injury occu | | AT SCENI |
| 70 | | | ece of Injury - A | njury - At home, ferm, street, fectory, office etc. <i>(Specify)</i> | | | | on (Street and Num Town, State) | | |
| 9 | 2 ☐ Accident inv | ermined 28e. Plu | ilding, etc. <i>(Spe</i> NKNOWN | | | | III PA | KK AAF RALI | | |
| Certification: To | 2 Accident inv 3 Suicide 6 C Co 4 Homicide | ermined 28e. Ple bu U fying Physician: To cal Examiner: On the | NKNOWN the best of my i | | | | place, and due to | | nenner as st | sted. |
| 2 | 2 Accident inv 3 Suicide 6 © Co 4 Homicide det | fying Physician: To cal Examiner: On the | NKNOWN the best of my less basis of exam | | vestigation, in my | | place, and due to | the cause(s) and me, date and place | nenner as st , and due to | ated. the cause(s) |
| edical Certification: To | 2 Accident inv 3 Suicide 6 © Co 4 Homicide 29a. Certifier (Check only one) | ermined 28e. Photo U U fying Physician: To cal Examiner: On the tiffer | NKNOWN the best of my less of examinating leted. | ination and/or invited and/or invite | 29c. Licer OX Print) | opinion, deeth | place, and due to a occurred at the tin | the cause(s) and me, date and place | nenner as sta , and due to ed (Month, L | ated. the cause(s) |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Reeves THELMA E APRIL 11:15AN 1999 19 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death 21279 MO BALTIMORE SMMMITAN HOSPITM. If Under 24 Hrs. 8. Date of Birth (Month, Day, if Undar 1 Yaar 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Months Days 1 □ M 200 216-12-8318 80 1/21/1919 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A 1 Yas 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 1 Yes 200No Specify: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) completed) College (1-4or 5+) Crown Cork and Seal Inspector 18. Mother's Name (First, Middle, Maiden Surname)

Usual Residence of Decedent the Maryland 10a State r le marked other than "natural", or items 23a or 28a-f show treumstic event, the Massical Examinat must be notified at MD Director 10e. Street and Number filed within 72 hours efter daath with 1115 Horners Lane Funeral 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 p 3 ₩idowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade com Elementary/Secondary (0-12) Hygiena. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other treumatic event. 17. Father's Name (First, Middle, Last) Be Josiah A. Nortrup Helen E. Wade 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) T. Nancy Quinn 615 Connelly Road Rising Sun, Maryland 21911 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/99 Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Eugeral Servica Licensee John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 23a. Parti. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical My orandel injanction Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ownary siclan and burial-transit that the death certificate be axecuted

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

artery disease Due to (or as a consequence of)

Due to (or as a consequenca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

20c. Location - City or Town, State

Baltimore, Maryland

24a. Was an autopsy

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 Yas 2 No

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Homa 5 Residence 8 Other (Specify)

26. Place of Death (Check only one)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

27. Manner of Deeth

Natural

2 Accident

3 ☐ Sulcide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. Licanse number

29d. Data signed (Month, Day, Year)

AJAM CHAWLA

5 Pending Investigation

6 Could not be

WD

12556

1 ☐ Yes 2 ☐ No

APRIL, 19, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOOD JAMBRIJAN HOSPITAL, 5601, LOCHROWEN ROUGEN MED WO 21735 31. Date filed (Month, Day, Year) APR 2 1 1999 32. Registrar Signature

State Registrar

attending physician for use as the burial

signed by the a

been si

has

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Completed by

Be

2

Certification:

Medical

Box 68760,

0

Division of Vital Records, P.

The law requires

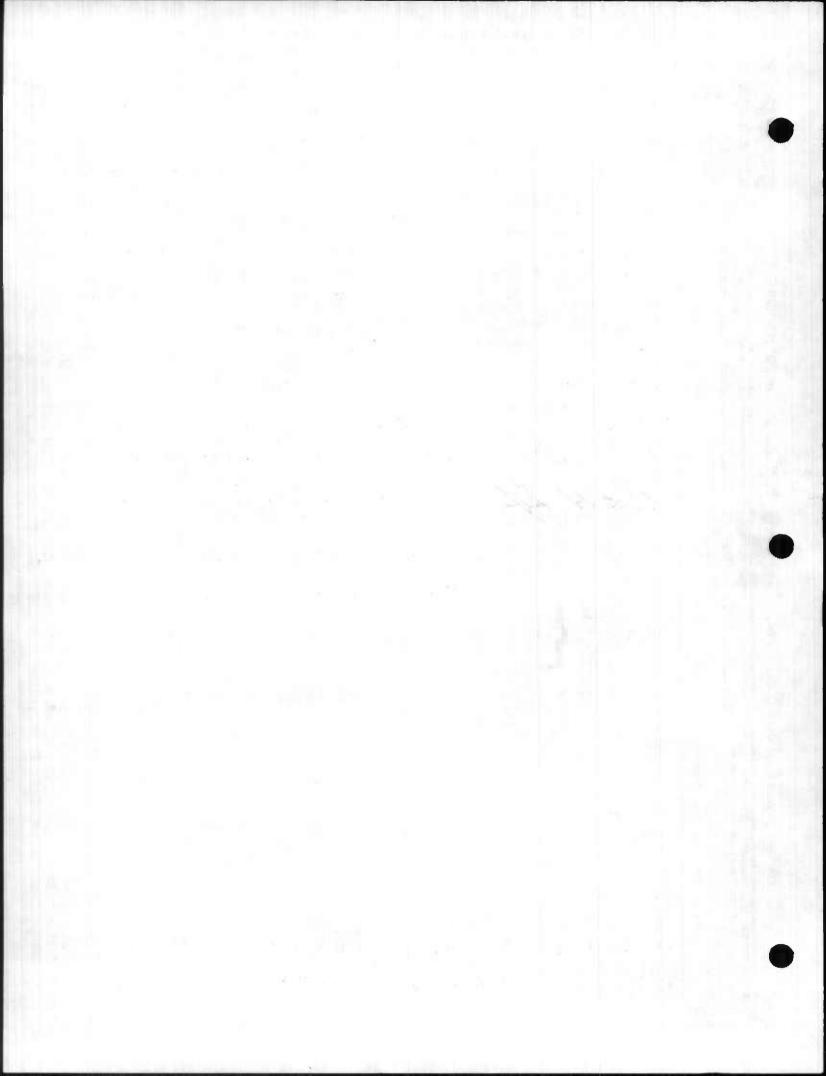
Physician

/Medical

Examiner

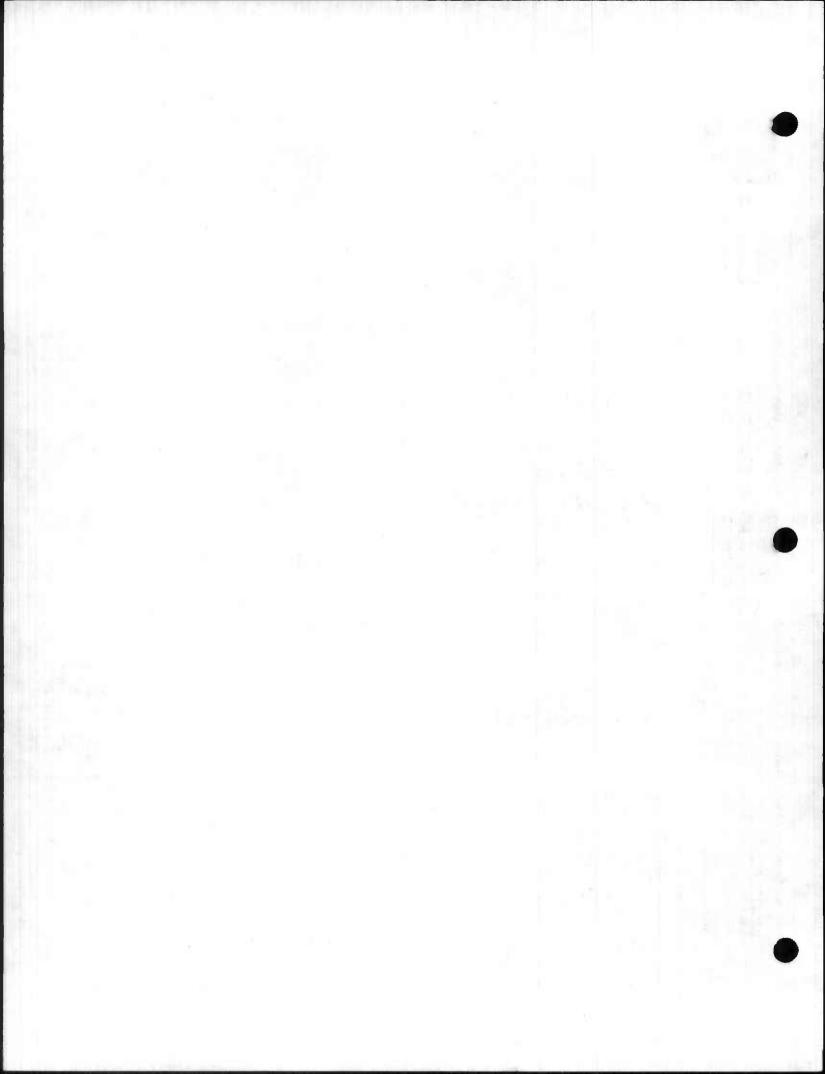
Funeral

Director



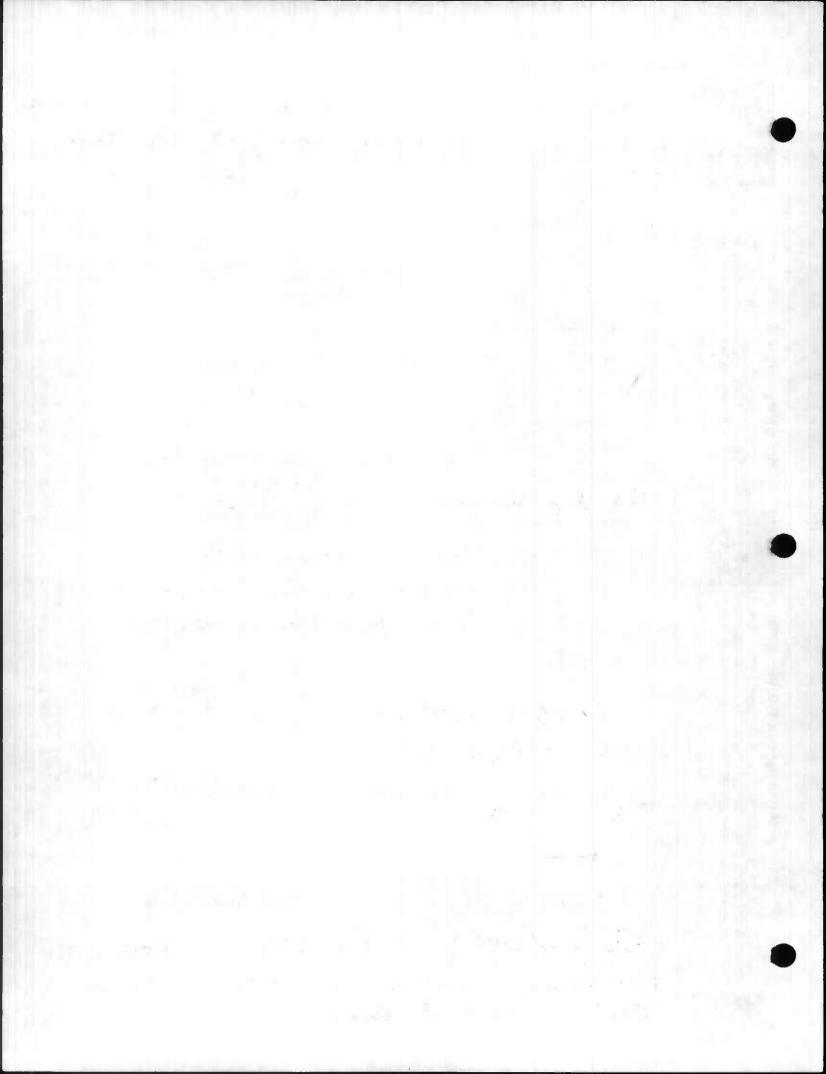
Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 3 0 5 2

| | Decedent's Name (First, Middle, Last) | Certificate of | Death | 2. Date of Deat | Reg. No. | | 3. Tima of Death | | |
|--|---|--|---|---|--|--|------------------------------|--|--|
| Physician (Modical | GEORGE HENRY SM | | | APRIL | 1 ¹ 8 ^y , 1 | 999 | 6:28AM | | |
| /Medical Examiner | 4a Facility Nama (If not institution, give street and num JOHNS HOPKINS BAYVI | , | | 4b. City, Town, or Lo BALTIMO | | 4c. County o | of Death | | |
| Funeral Director | 216-24-4797 ¹ ⊠ ^{M 2□ F} | 7. Aga (In yrs. last birth | day) If Under 1 Yaar Months Days | Hours Min. | 8. Data of Birth (Alexandry) Pay, Year 1929 9. Birthplaca (State of Country) MD. | | | | |
| Maryland 4 show 1 st at 1 st at 1 st at | Usual Residence of Decedent 10a. State 10b. County BALTIMORE | | 10d. fnside Clty I | | | | | | |
| after death with the Manylar or Hems 23a or 28a-f show infine must be notified at 7 Funeral Director | 10e. Street and Number 7157 GOUGH STREET | _10 | Og. Citizen of W | | itry? | | | | |
| E G | 11. Marital Status 1 □ Nevar Msrried 2 ☑ Married 1 □ Nevar Msrried 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decer Armed For 1 ☑ Yas 11 Yes, Give Year or Da | 2□№ 1951 | 13. Was Decedent of Hif Yes, specify Cubin 1 ☐ Yes 2 ☒ No | lispanic Origin? (Spo an, Mexican, Puerto Specify: | ecify Yea or No- Rican, etc.) | Black | - Americ k, White, WHI | | |
| filed within 72 ho Hygiene. ther then "neturi ort, the Midles! | 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1- | | Decedent's Usual Occup Give kind of work done life. DO NOT use retired RINTER/TYPE | PAPER | | dustry | | | |
| Saby W | 17. Father's Name (First, Middla, Last) JOHN SMITH | | | 18. Mother's Name (First, Middle, Maiden Surneme) MARY WAREHEIM | | | | | |
| th and | 19a. Informant's Name/Relationship (Type, Print) JOAM M. SMITH/WIFE | | Mailing Address (Street 57 GOUGH | | | | | | |
| 10 T | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify) | cemetery, | Disposition (Name of crematory or other place) AWN CEMETER | ematory or other place) | | | | | |
| permit. Pag Department Important: I any injury o ance. | 21. Signatural of Funerel Service Licensee | | N, INC. IMORE, MD. 21224 ory arrest, Approximate Interval Between | | | | | | |
| Clar/Medical Examiner Standing physician and attending physician and for use as the burlal-transit clar/Medical Examiner | Sequentially list conditions, | Due to (or as a co | ISION Insequence of): DLESTEROU | | CTION | | | Onset and Death | |
| that the death cent led by the attendin detached for use y Physician/M | Part II. Other significant conditions contributing to dea | ath but not resulting in t | the underlying cause give | e given in Part f. 23b. | | b. Did tobacco use contribute to the cause | | | |
| w requires the specific specif | DIABETES MEL | LITUS | | | 1 Va | | av | bably 4 Unknot bere autopsy findings allable prior to mplation of cause death? | |
| certificate ha rector, paga : | | | | | 1 ☐ Ye | | 1[| Yes 2 No | |
| his his | 25. Was case referred to medical axaminer? Yes 20 No | patient 2 PR/Outp | me of 28c. Injury | | | eck only one) 5 Residence 6 Other (Specify) Describe how injury occurred | | | |
| tal or Attending P is after death. al Director: After t led in by the funers Certification: | all outside Could not be | of fnjury - At home, farm g, etc. (Specify) | n, street, factory, office | | | ocation (Street and Number or Rural Route Numbry or Town, State) | | | |
| ne Hospital of no 24 hours at no 24 hours at no 124 hours at n | 29e. Certifier (Check only one) Certifying Physician: To the base and manner. | is of examination and/ | deeth occurred at the tir or investigation, in my o | ne, date and place, pinion, death occurr | end due to the ca ed at the time, da | use(s) end ma ate and plece, a | nner as si ind due to | tated. the cause(s) | |
| To the To the comple | 29b. Signatura and title of certifier | | 29c. Licens | e number | 29 | Pd. Data signed | (Month, | Day, Year) | |
| 10/3 | 30. Name and address of person who completed cause HOBERT CONNORS | | ype, Print) 005 NORTH PU | UL BUIL | SHITE | IM BA | TIM | DRE NI | |
| State Registrar | | gistrar's Signature | 1. | , , , , , , | | , oc 51 h | -, 111 | 111/ | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 4

| | Item: 27 per M.D G-770 4/21/99 reb Certificate of De | | (Dooth |
|--|---|---|------------|
| Physician /Medical | TO CHO LEGO LO | Alku 2. Data of Death Month Dey Year O4:4 | to Am |
| Examiner Funeral Director | PLINGE GEORGE'S HOSPITAL CENTER CO. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 | City, Town, or Location of Death Proce Georges If Under 24 Ho. B. Date of Birth Hours Min. Month, Day, Year) O - 13 - 1952 Guyar | or Foreign |
| Maryland H show Hed at | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MA Baltumane, SIVER Sorings | 10d. insida Ci | Ity Limits |
| .0020 hours after death with the Maryland hours of terms 23a or 28s-f show all Exeminet must be notified at ad by Funeral Director | 1 Nevar Marriad 2 Married 1 Yas 2 XNo 1 Yes 2 XNo 5 | 10g. Citizen of What Country? U. 5 A panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 114. Race - American Indian, Black, White, etc. Specify: A 5 1 an | |
| d 21215-0020 filed within 72 hours af thygiene. wher then "natural", or ent, the Medical Exam e Completed by F | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th grade NA 16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired) College (1-4or 5+) Cas Station | attendent Gas Station | |
| laryland 2 should be flie and Mentel Hy is marked other summitic svem To Be | Abdulkarin Shaikh | 8. Mother's Name (First, Middle, Maiden Sumame) FateMa A . Master d Number or Rural Route Number, City or Town, State, Zip Code) 21 | 0903 |
| Battimore, Mc permit. Pages 1 and 2: Department of Health at Important: If item 27 (a any Injury or other tree | ASIF G. Maotes - Cousin 655 Northan 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) 20b. Place of Disposition (Name of cametery, cremetory or other place) King Memorial F. 22. Name and Addrass of Cousins and Cousins and Addrass of Cousins and Addrass of Cousins and Addrass of Cousins and Cousins and Addrass of Cousins and Cousins | aptun Drive Silver Springs, Mo Date 20c Location - Bity or Town, Stata Parte 4-13-99 Randallstown, M | 1d 1215 |
| x 68760, certificate be executed ding physician and ding physician and se as the buriel-fransit Medical Examiner | 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Bue to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | Interval Bet Onset and | tween |
| that the death certing by the attending detached for use a Physician/M | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given The befes Mells fes | | of death? |
| The law requires that The law requires that sate hes been signed b, page 2 should be dete Completed by PI | Osteonyeltf15 | 24a. Was an eutopsy performed? 24b. Were autopsy available prior completion of death? | to |
| Vital Re- ulclan: The lav certificate hes rector, page 2 | 25. Wes case referred to medical | 1 ☐ Yes 2 No 1 ☐ Yes 200 | No |
| ision of trending Phys death. ctor: After this y the funeral df floation: To | examiner? 1 Yes 20 No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 27. Manner of Deeth 1 Natural 5 Pending (Month, Day Year) 28b. Time of injury a Work? | 4 Nursing Home 5 Residence 6 Other (Specify) | nber, |
| DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Madical Examiner: On the basis of examination and/or investigation, in my opin and mennar stated. | ion, death occurred at the time, date and plece, end due to the ceuse(s | s) |
| To the com | 29c. Signature and title of certifier 29c. License in DS | 29d. Date signed (Month, Day, Year) 2298 April 10, 1990 | ĵ |
| State | 30. Name and address in the sampleted cause of death (Item 23e) (Type, Print) 1925 Grelyway Center Drive 9046 T 31. Date filed (Month, Day, Year) APR 2 1 1999 | 4, Greenbelt, MID 20706 | |



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State of Maryland / Department of Health and Mental Hygiene

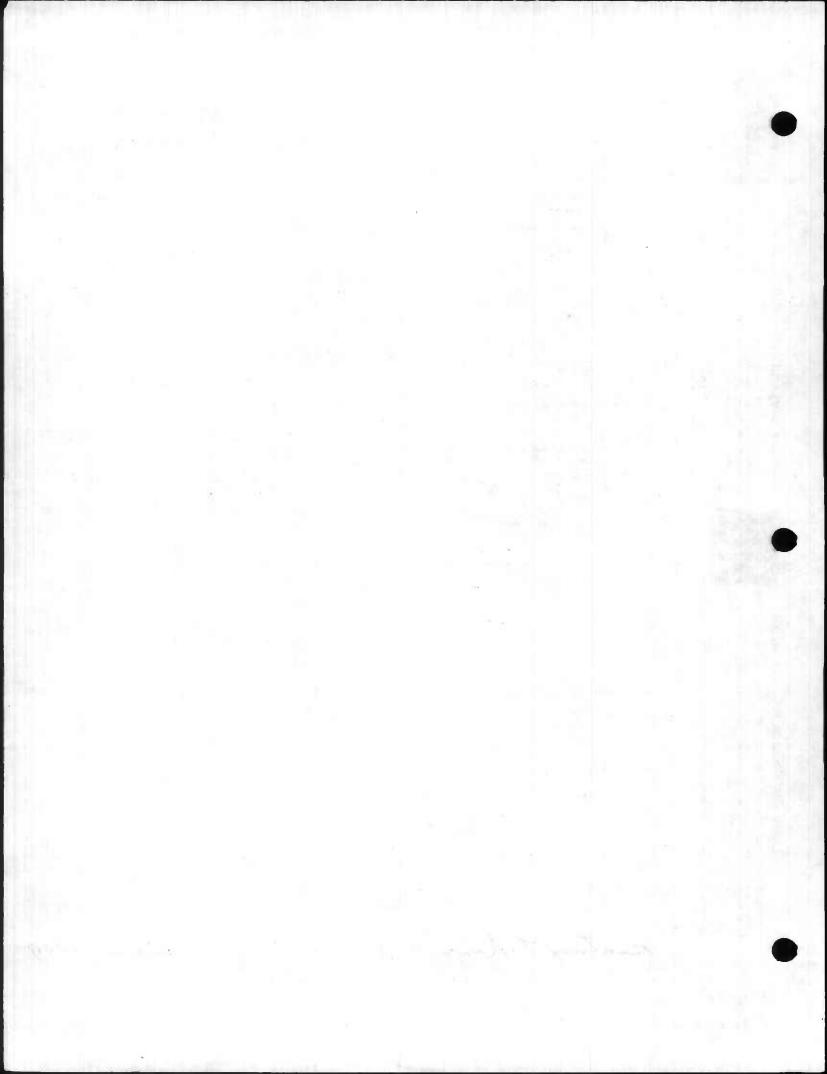
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| liller | Sullivan | | | Certi | ficate | of De | ath | | Reg. No. | 9 | 13054 | |
|--|--|--|---|---|-------------------------------|--------------------|----------------------|---|----------------------|--------------------------|--|--|
| hysician | 1. Decedent's Name (First, Middle, Flora Miller Su | | | | | | | 2. Date of De Month | eeth Dey | Year | 3. Time of Deeth | |
| /Medical | | | | | | | | Februa | | 1999 | 12:55 P.M | |
| xaminer | 4a Facility Neme (If not institution, | give street and number |) | | | 4b. C | ity, Town, or L | n, or Location of Death 4c. County of Death | | | | |
| | Saint Joseph Me | dical Cente | ical Center Tows | | | | | | | timor | | |
| ineral | | 5. Sex 7. A | | 1 | If Under 1 Y Vonths D | | lours Min. | 8. Dete of Bi (Month, Di | rth ay, Year) | 9. Birthp | lace (State or Foreign | |
| ector | 157-34-6679 | | 100 | O Yrs. | | -10 | | Sept. 1 | 7,1898 | Mai | ne | |
| E | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City, Town or Location | | | | | | | 1 | 0d. Inside City Limits | |
| fled a | New Jersey Uni | on | | | | | | | | | 1 X Yes 2 No | |
| rect | 10e. Street and Number | | | | 10f. Zip Co | de | | 10g. Citizen of W | | | itry? | |
| Funeral Director | Apt. 2B Dehart P | 1. | | | 0720 | 2 | | | United | State | es | |
| 190 | 11. Marital Status | 12. Wes Decedent | Ever in U. | S. 13. We | s Decedent | of Hispar | nic Origin? (Sp | ecify Yes or No | o- 14. Rac | ce - Americ | | |
| ser than "natural", or the rt, the Medical Examinar Completed by Fur | 1 Never Married 2 Merrie 3 Widowed 4 Divorced | Armed Forces d 1 Yes 2 If Yes, Give Year or Detes; | No | S. 13. Wes Decedent of Hispanic Original Yes, specify Cuban, Mexican 1 Yes 2 No Specify: | | | | Hican, etc.) | Specif | ck, White, y: wh | eic. ite | |
| | | Education | | 16a. Deceder | nt's Usuel O | ccupation | n ng most of work | bin- | 16b. Kind of B | usiness/Inc | dustry | |
| ald | (Specify only highest Elementery/Secondary (0-12) | College (1-4or | 5+) | life. DO | NOT use re | etired) | y most or won | niy. | | | | |
| Con | | 2 | | mus | sic te | 7 | | | mus | | | |
| aumatic event, To Be C | 17. Fether's Neme (First, Middle, L | | | | | | | | , Maiden Sumen | iden Sumeme) unknown) | | |
| | | iller | | | | | (unknow | wII) | (WIKNOW | vI1) | | |
| | 19e. Intorment's Neme/Reletionsh | | | | | | | | | own, Stete, Zip Code) | | |
| | Chuck Connolly/g | randson | 110.111110111 1110. 20110011, 12 2120 | | | | | | | | | |
| | 20a. Method of Disposition 1 X Burial 2 Cremetion | R □ Bemovel from State | 20b. Pl | lace of Dispositi emetery, creme | ion (Name of tory or other | r place) | i | Dete | 20c. Location | - City or To | wn, State | |
| | 4 ☐ Donetion 5 ☐ Other (Sp. | | | lywood . | | | | | Union, | | | |
| 8 | 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Mitchell—Wiedefeld Funeral 6500 York Rd. Baltimore, MD 21212 | | | | | | | | | | | |
| 8 | | | | | | | | | | | | |
| | 231 att1. Enter the disease, or disease, or hock, or heen teilure. List o | omplications that cause | d the death | . Do not enter | the mode of | dying, su | uch as cardiac | or respiretory | | 212 | Approximate Intervel Between | |
| an | Control tollare. Elst o | ny one cause on each | iii ro. | | | | | | | | Onset and Death | |
| a1 | Immediate Cause (Finel disease or condition | Sepsi | is | | | | | | | | 4-5 days | |
| | resulting in deeth) | a | Due to (or as a consequence of): | | | | | | | 1 | 2 | |
| ner | | Urina | - | ract In | | on | | | 100 | 19 | 4-5 days | |
| Examiner | Sequentially list conditions, | D | | to (or es e consequence of): ed Pelvis | | | | 111 | VI | * | | |
| E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | Fract | tured | | | | 1 | 11 | HEDICAL ELA | | 6 days | |
| edical | thet initiated events resulting in death) Last | G | CDue to (or es a consequence of): | | | | | ON APPROVED BY MEDICAL PRIME | | | | |
| | | | DOTTIFICA | | | | | 11. | | | | |
| an | | d | | | | | U | | | 1 | | |
| 18 | Pert II. Other algnificant condition | contributing to death I | ontributing to death but not resulting in the underlying cause given in Pert I. | | | | | 23b. Did | tobacco use co | entribute to | the cause of death? | |
| cala has been signed by the attendar, page 2 should be detached for use Completed by Physician/M | Dehydration | | | | | | | 10 | Yes 210 No | 3 Prol | bably 4 Unknown | |
| | Dellyttederon | | | | | | | | | 1 | | |
| | | | | | | | | | an autopsy ormed? | av | ere eutopsy findings allable prior to | |
| ple | | | | | | | | Appr | oval | of | mpletion of cause death? | |
| rector, paga 2 Be Comp | | | | | | | | | Yes 2⊠No | 10 | Yes 2 No | |
| Be | 25. Wes case reterred to medical examiner? | | 26. Place of Deeth (Check only one) | | | | | | | | | |
| To | Yes 2□ No | Hospitel: | ent 201 | ER/Outpatient | 3 DOA | Other: 4 | 4□ Nursing H | | idence 6 🗆 Oth | | | |
| | 27. Manner of Death 1 □Neturel 5 □ Pending | 28a. Dete of Inju (Month, De | ury ny Year) | 28b. Time of Injury | 28c. | Injury at Work? | | 28d. Describe | how injury occur | redSub | ject fell | |
| Certification: | Accident investige | tion 02-20-19 | 200 | ınknown | | | 2X) No | while w | alking : | in he | r grandson | |
| tific | 3 Suicide 6 Could no determin | t be 28e. Place of In | | me, term, street | | fice | | 28f. Location (| Street and Numi | ber or Rurs | l Route Number, Lvern Avent | |
| 3 | The state of the s | | 1-2000 | Hou | use | | | | aven, Ma | | | |
| edical | 29e. Certifier 1 Certifying | Physician: To the best aminer: On the basis of | of my know | viedge, death or | coursed et th | ne time, d | late end place, | and due to the | cause(s) end m | anner as s | tated. | |
| | one) | and manner si | ated. | on enteror mives | | | | rou at the time, | | | | |
| 2 | 29b. Signature and title of certifier | 10 | | | 29c. Lic | cense nui | mber | | 29d. Date signe | ed (Month, | Day, Year) | |

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D16492



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Dacedant's Nama (First Middle Last) 2. Data of Death Day Month Vaar Rosearle Ε. Sevier April 12, 1999 3:30 PM 4e. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton TOWSON If Under 24 Hrs. Baltimore If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) Days Hours 1□ M 2\ F Yrs 213-20-5817 85 March 11,1914 Vermont Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10e. Street end Number 10f, Zip Coda 10g. Citizan of What Country? 7001 N. Charles Street Apt 219 21204 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Yas 2 ∑Xio If Yas, Giva Yeer or Datas: 1 Navar Marriad 20 Married 1 Yas 2 10 10 Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working tifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) Licensed Practical Nurse 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Daniel F. De Barge, Sr. Elva С. Cox 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) John B. Sevier Husband 7001 N. Charles Street Towson, Maryland 21204 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete M∑Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 4/14/99 Centerville, MD Chesterfield Cemetery 22. Nama and Addrass of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 21211 Part Enter the disease, or complications that caused the daeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or hard failura. List only one cause on each line. Approximeta Intarvel Between Onset end Death Acute Myocardial Infavorion Due to (or as a gonsequence of): Immediata Cause (Final diseesa or condition resulting in daalh) Minutes Sequentially list conditions, if eny, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of) Due to (or es e consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 2 XN0 1 ☐ Yes 2 ☐ No 25. Wes casa rafarrad to medical exeminer? 26. Placa of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dala of Injury (Month, Day Year) 27. Manner of Daath 28b Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Director

Funeral

Ď,

Completed

To

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiers. Important: If flem 27 is marked other than "natural". • Indicate traumitic severe than "natural". • Indicate the page of other traumitic severe than "natural". • Indicate the page of other traumitic severe than "natural". • Indicate the page of other traumitic severe than "natural". • Indicate the page of other traumitic severe than "natural". • Indicate the page of the page of

Examiner

Natural

2 Accident

4 Homicida

(Check only one)

29b. Signetura end the of certifier

3 Suicida

29a. Certifiar

physician and the burial-transit Box 68760, esn signed by the a d be detached f Division of Vital Records, P.O. been si this funeral To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by Medical

Physician/Medical by Completed Certification:

State Registrar

SHILADI. MD 31. Data filad (Month, Day, Year)

5 Panding

invastigation 6 Could not be datarmined



28d. Dascribe how Injury occurred

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha time, date end place, and dua to tha cause(s) end menner es steted.

2 Madical Examinar: On the basis of examination and/or invastigetion, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) end manner stated.

D-12849

29d. Data signed (Month, Day, Year)

30. Nama and eddrass of person who completed cause of death (Itam 23a) (Type, Print)

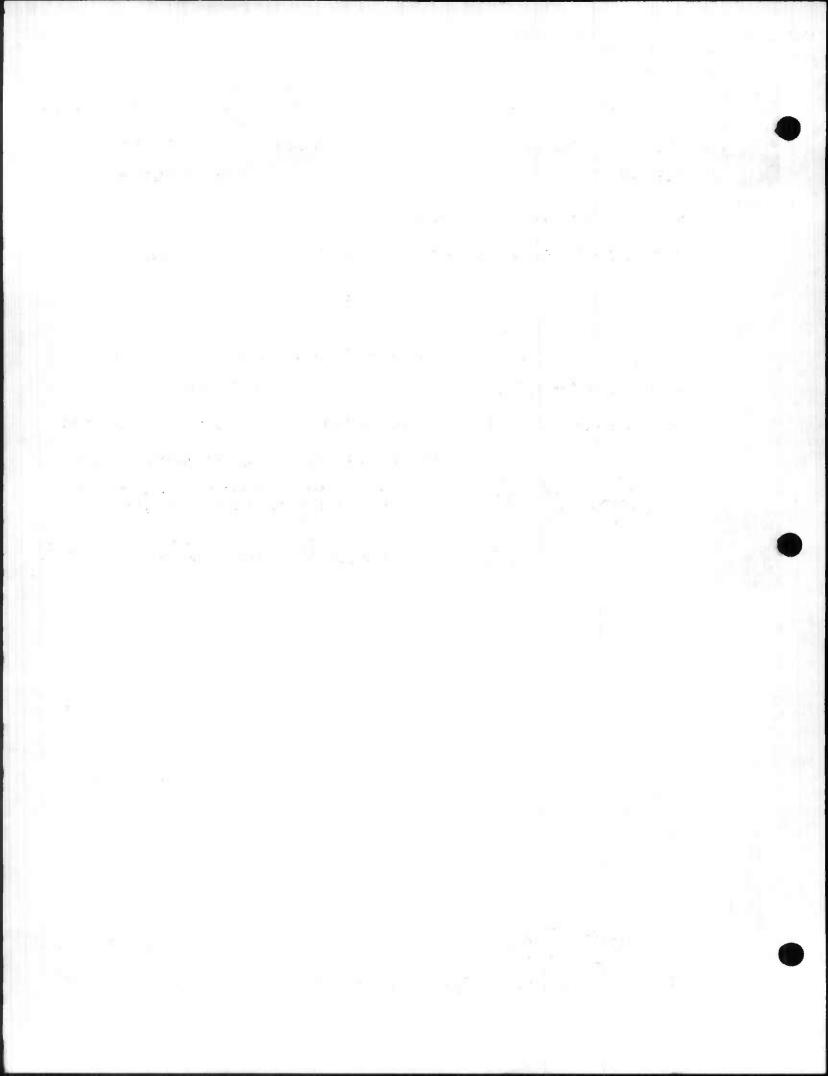
Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

7600 OSLER Dr. TOWSON. Md. 2404

32. Registrar's Signature

APR 2 1 1999

DHMH 16 Ray 6/95



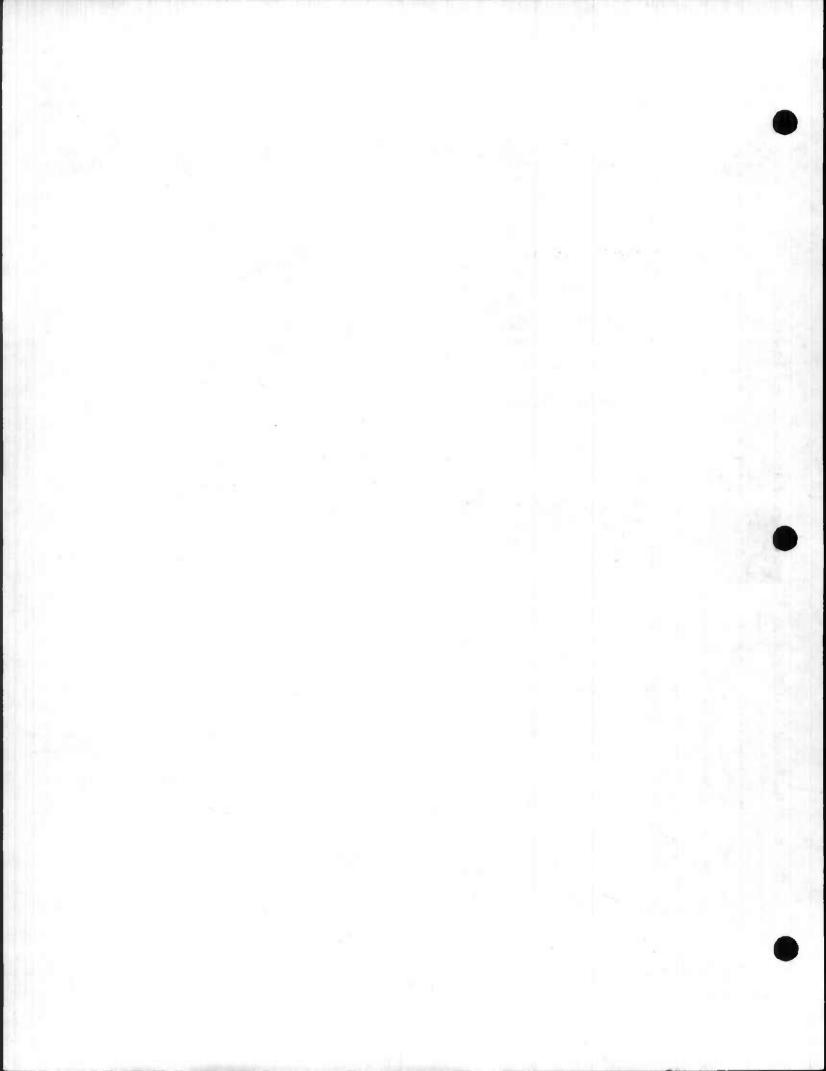
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jane P. Sprigg 12, 1999 April /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Home, 3610 Keystone Avenue Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sept. 22,1915 Maryland Birthplace (State or Foreign Country) **Funeral** 1 M XX F Months Days Hours 83 212-48-6666 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location "natural", or items 23s or 28s-f show adiral Examiner must be notified at 1XXYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3610 Keystone Avenue 21211 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Evant Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: by 3℃Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Theodore Canter Jane Margaret Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 Keystone Avenue Baltimore, MD 21211 John Sprigg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State XIX Buriai 2 Cremation 3 Removal from State Poplar Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/15/99 Cockeysville, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road Baltimore, Maryland 21. Signature of Funeral Service Vicense 23a. Part). Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Cerebellan /Medical 2 cuk Examiner Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown signed I þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No After this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? L Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homleide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier Medicai (Check only within 2 ŝ 29b. Signatury and title of ceptile 29c. License number 29d. Date signed (Month, Day, Year) 023076 Coles cocleren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimine Md 212/1 DIAMOND ()CHARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Ray 6/95

State Registrar

APR 2 1 1999

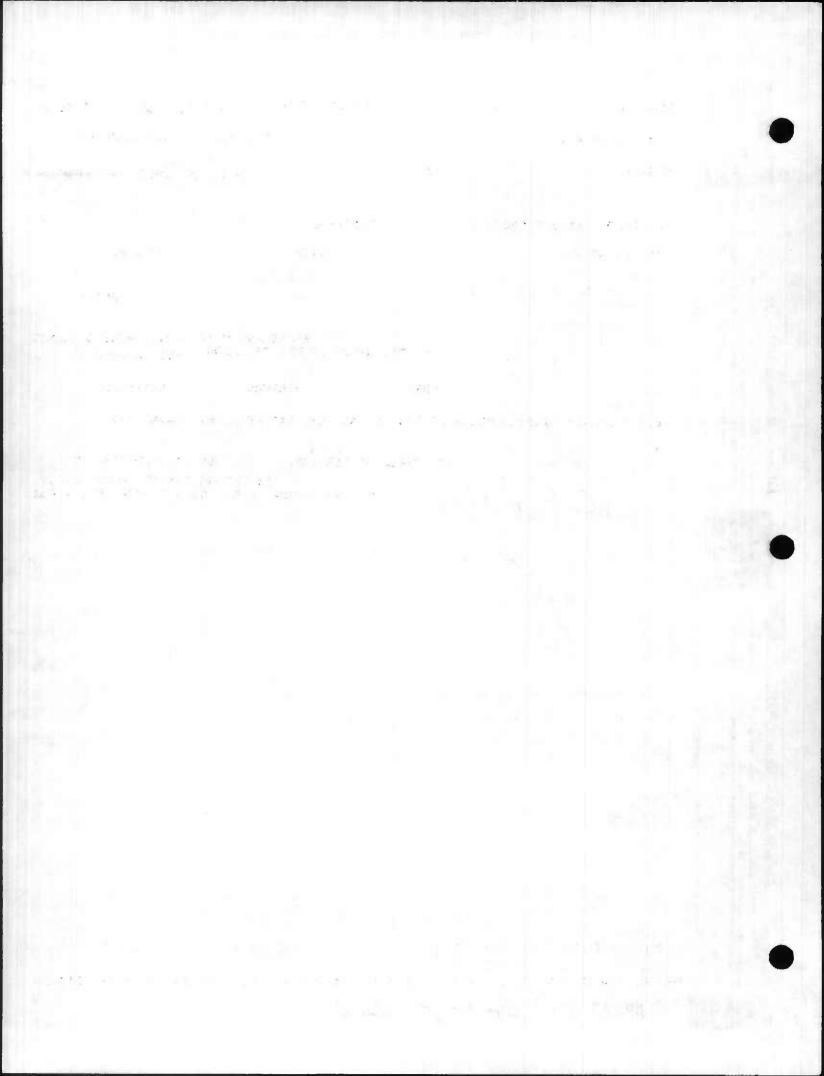


State of Maryland / Department of Health and Mental Hygiene

| | | | C | ertifica | te of | Death | | Reg. No. | 130 | 57 | | | |
|--|--|---|---------------------------------|---|-------------------------------------|--|---|-----------------------------------|---|--------------|--|--|--|
| Physician | 1. Decedent's Neme (First, Middle, Las | | | | | | 2. Date of Dea | ath Day | 3. Time | of Death | | | |
| /Medical | BLANCHE | CAROLYN | | SON | NENL | EITER | APRIL | 20, 1999 | 6:40 |) AM | | | |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | | | | Location of Death | | of Death ARUNDEL | | | | |
| Funeral | 5. Social Security Number 6. S. 216 – 20 – 980 2 | ex 7. Age (in | yrs. last birthda | Months | er 1 Year Deys | | 8. Dete of Bird (Month, Da | h y, Year) | 9. Birthplece (State Country) | e or Foreign | | | |
| Director | 216-20-9802 1 M 2AJF 73 Yrs. NOV. 15, 1925 Mar Usuel Residence of Decedent | | | | | | | | | | | | |
| wor. | 10e. State 10b. County | 100 | c. City, Town or | Location | | | | | 10d. inside | | | | |
| the Maryler 28a-f show nout ad at | MARYLAND ANNE | ARUNDEL | | PAS | SADEN | IA. | | | 1 □ Y∈ | s 2 No | | | |
| ufer death with the Marylend refers 23s or 28s-f show rines must be notified at Funeral Director | 10e. Street and Number 515 SYLVAN WAY | | | 10f. Z | ip Code 21 | 122 | | 10g. Citizen of V U.S | | | | | |
| urs after ur, or its marries by Fu | 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Yeer or Detes: | in U,S. 1 | | | Hispanic Origin? (en, Mexican, Pue Specify: | Specify Yes or No rto Rican, etc.) | | a - Americen Indian, ck, White, etc. | | | | |
| | 15. Decadent's Ed (Specify only highest gra Elementary/Secondary (0-12) | ucation de completed) College (1-4or 5+) | 16e. De (G | cedent's Us ive kind of v b. DO NOT | ual Occup ork done use retire | pation during most of we | orking NT CHIEF | 16b. Kind of Br | siness/Industry | UNTY | | | |
| hould be filed within the Mantel Hygiene. marked other than matic event, the M | Libinoritary Goodinary (G-12) | 1 | OF T | HE RIC | SHT C | F WAY DI | VISION | PUBLIC | WORKS | | | | |
| d oth | 17. Fether's Neme (First, Middle, Last) | | | | | | me (First, Middle, | | | | | | |
| ould Men | ALAN | | CURRY | | | BLANCE | | | ERTON | | | | |
| d 2 should be file the and Mentel Hy 7 is marked othe traumatic event | 19e. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C GEORGE SONNENLEITER, JR. HUSBAND) 515 SYLVAN WAY, PASADENA, MARYLAND 21122 | | | | | | | | | | | | |
| CENL | 20e. Method of Disposition | | 0b. Place of Di | sposition (N | ame of | | Date | | City or Town, Stete | | | | |
| 8 = 8 | 1X Buriel 2 ☐ Cremetion 3 ☐ | | cametery, o | | | | 1/23/00 | | | | | | |
| permit. Pages 1 a Department of Hea Importants if item any injury or othe other. | 4 Donetion 5 Other (Specify) MD. VETERANS CEMETERY 4/23/99 CROWNSVILLE, MD. 21. Signature of Funeral Service Licensia. 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., SECOND AVENUE, S.W., GLEN BURNIE, MD. 2106 | | | | | | | | | | | | |
| 40244 | when | A) Ade | | | | | | | | | | | |
| | 23a. Part1. Enter the disease, or compositions shock, or heart feilure. List only | one cause on each line. | deetri. Do not | enter the m | ode of dyl | ng, such es cardi | ic or respiratory a | rest, | Approxim Interval B Onset en | Between | | | |
| Physician /Medical | Immediate Cause (Final | 100 0000 | NE=A | | EN | DOMEDIA | VI CARC | 210000 | | | | | |
| Examiner | Immediate Cause (Final disease or condition resulting in deeth) e. ADVANCED METASTATIC ENDOMERIAL CARCINOMA THREE YS. Due to (or es e consequenca of): | | | | | | | | | | | | |
| | | Due | to (or es e con | sequenca o | 1): | | | | | | | | |
| cate be executed physician and is the burial-transit edical Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury their initieted events resulting in death) Lest Due to (or as a consequence of): | | | | | | | | | | | | |
| an a | | | | | | | | | | | | | |
| ificate be any physician as the burial edical Ex | | | | | | | | | | | | | |
| ath certificate of the certifica | | | | | | | | | | | | | |
| as that the death cengned by the attending be detached for use by Physiciar/N | | 0 | | | | | | | | | | | |
| the at | Pert II. Other significant conditions co | ontributing to death but no | t resulting in th | e underlying | cause gi | ven in Part I. | 23b. Dld | tobacco use co | ntribute to the caus | e of death? | | | |
| as that the igned by be detacted by Ph | RECURIZENT DEEP VENUS THROMBOSIS | | | | | | | | | Unknow | | | |
| require | | | | | | | | en eutopsy rmed? | 24b. Were eutops available pric | or to | | | |
| 8 50 D | | | | | | | | | of deeth? | | | | |
| F # 6 | | | | | | | | Yes 2 DHNo | 1 ☐ Yes 2 | ₽-No | | | |
| Physician: The Lartinis certificate he rail director, page | 25. Wes case reterred to medical exeminer? | Hospital: | | | Ott | har | eath (Check only | | /A // 1 | | | | |
| or Attending Physician: The description of the desc | 27. Menner ot Deeth | 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye. | | | 28c. Inju Wo | 4 Li Nursing | Home 5 13-Resi | how injury occur | | | | | |
| th. Afte fune | 1 Naturel 5 Pending 2 Accident Investigation | | ar) Injui | y M | | ork? Yes 2 No | | | | | | | |
| tal or Attending P rs after death. at Director: After t led in by the funers Certification: | 3 Suicide 6 Could not be determined | B 28a Place of Injury. At home term except feeton, office | | | | | 28f. Location (Street and Number or Rural Route N City or Town, State) | | | | | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: | 29a. Certifier (Check only one) 1 Certifying Physical Examples (Check only one) | ysician: To the best of my ilner: On the bests of exa and menner steted. | knowledge, de minetion end/o | eeth occurre investigetion | ed et the ti on, In my o | ime, dete end pled oplnion, deeth occ | e, end due to the curred et the time, | ceuse(s) end m date and place, | enner as steted. end due to the ceus | e(s) | | | |
| ro the complex | 29b. Signeture end title of certifier | | | 2 | 9c. Licen | se number | | 29d. Date signe | d (Month, Day, Year |) | | | |
| ->-0 | P. Ranga | ragan, M | · D | | Do | 0542 | 88 | APRIL . | 20th 190 | 19 | | | |
| | 30. Name end eddress of person who | 9 | | | | | | | - ' ' | , , | | | |
| | DR. R. RANGARAJAN, | | | | DANCE | T DOND | TEN DIEN | ITE MAD | TT 33TD 040 | 60 | | | |
| | | | 21 1 01111 | ACE D | KAMCI | i ROAD, | PLEN DUKI | ILE, MAR | YLAND ZIO | 00 | | | |

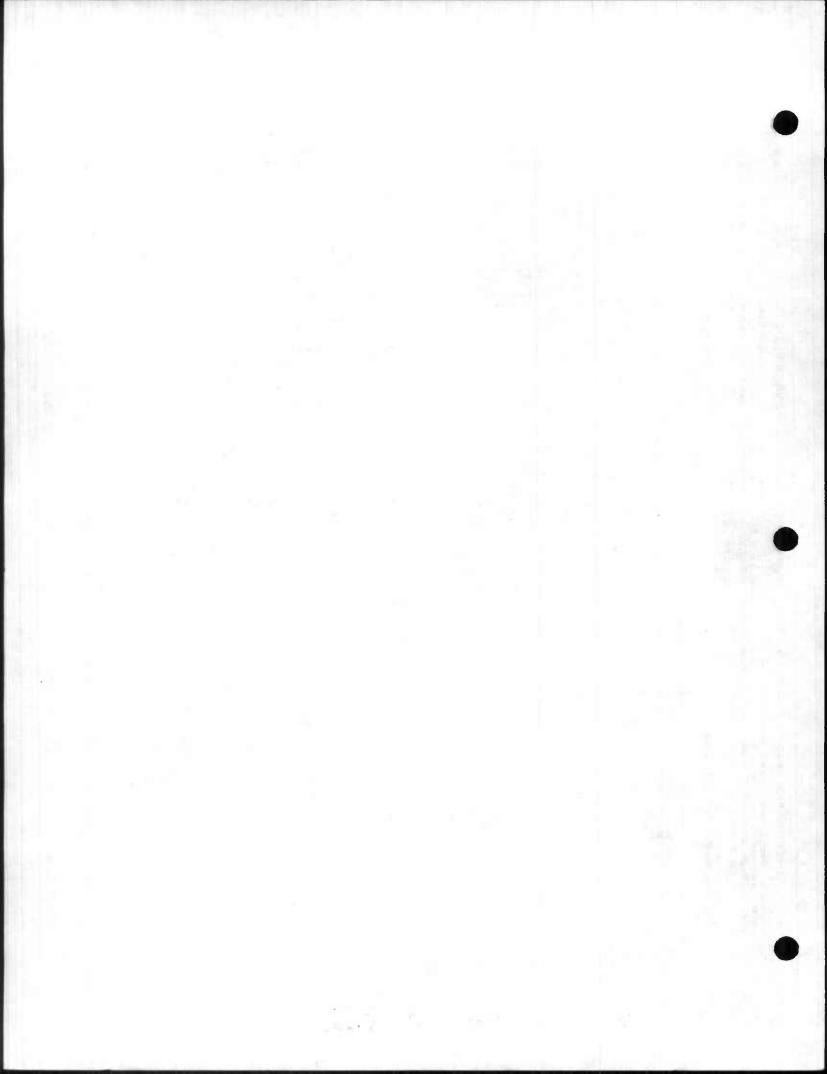
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

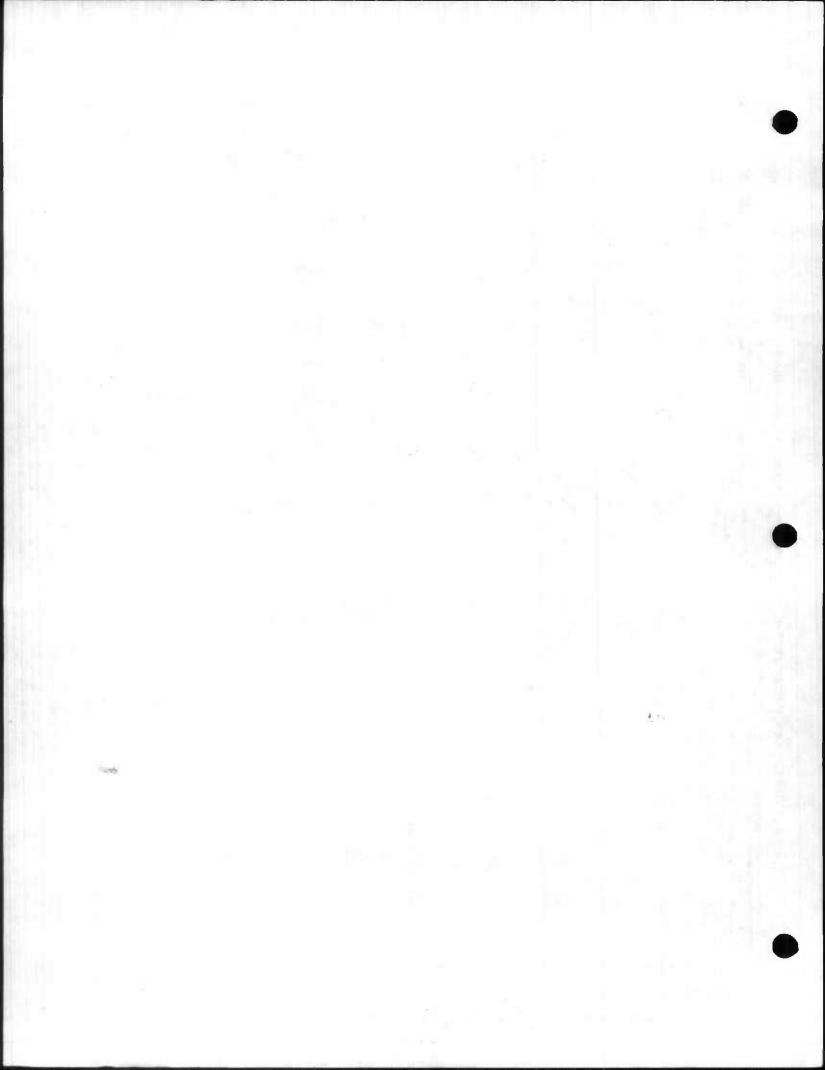
| | | · | Cer | tificate of | Death | | Reg. No. | 1 | 3058 | |
|--|---|--|---|-----------------------------------|---|--|--|---|---|--|
| Physician | Decedent's Neme (First, Middle, LAHOMA EARNES' | LASI) FINE SOUTH | 186 | | | 2. Dete of De Month | Dey | Yeer | 3. Time of Death | |
| _/Medical | 4a Facility Name (If not institution, | | | | 4h City Town or | APRIL Location of Deat | | 999 | 12:30 P.N | |
| Examiner | 4650 DOWER DR | | | 1 1 1 1 1 | | TT CITY | 4c. County | HOWAI | RD | |
| uneral irector | 5. Social Security Number 446-34-0246 | Sex 7. Age (In yrs 1 M 2X) F 84 | . last birthday) Yrs. | If Under 1 Yea Months Days | | | th by, Year) | 9. Birthp Court OKL | place (Stata or Foraign htry) AHOMA | |
| | Usual Residence of Decedent 10a. State 10b. County | 100 C | ity, Town or Loc | eation | | | | 14 | 0d. Inside City Limits | |
| Mad at | MD HOWAI | | LICOTT | | | | | | 1 ☐ Yes 2 No | |
| items 23e or 25e-f showner must be notified at funeral Director | 10e. Street and Number | m | | 10g. Citizen of V | | ntry? | | | | |
| pra last | 4650 DOWER DRI | | | US | | | | | | |
| 72 hours after death vatural, or items 23/ Scal Examiner must ited by Funeral | 11. Merital Status 1 Never Merried 2 Married Widowed 4 Divorced | 12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No Hyes, Give Year or Detes: | | Yes, specify Cu | Hispanic Origin? (: ban, Mexican, Pue Specify: | Specify Yes of No rto Rican, etc.) | Specify | ece - American Indian, leck, White, etc. | | |
| Scal peter | 15. Decedent's | | 16a. Decede | ent's Usual Occi | ipation | ndrina | 16b. Kind of B | usiness/Inc | dustry | |
| rt, the Medical | Elementery/Secondary (0-12) | College (1-4or 5+) 4 YEARS + | | ONOT use retir | e during most of wo | Anny | EDI | JCATIO | ONI | |
| | 17. Father's Name (First, Middle, La | | 1 00 | TOOL IL | | me (First, Middle. | | | | |
| To Be | ALONZO GATLIN | | | | 18. Mother's Name (First, Middle, Maiden Sumama) OLLIE JAMES | | | | | |
| | 19e. Informant's Neme/Ralationship | | | | | Rural Route Number | er, City or Town, | wn, Stata, Zip Code) | | |
| ž | KAREN HARGIS | DAUGHTER | 4650 Place of Dispos | DOWER D | RIVE ELI | Deta Deta | | 2104 | | |
| ury or of | 20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion, 5 Other (Special Service Lice) | on - City or Town, State OKLAHOMA | | | | | | | | |
| certificate has been signed by the attending physician and mapped of the property page 2 should be detached for use as the burial-transit and property and proper | 23a. Part Intar the disease, or conditions or heart feiture. List on Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other eignificant conditions 25. Wes casa referred to medical | a. Supranuleum Due to (b. Adjustum Due to (c. COP D Due to (d. | or as a consequence or a | pence of): | iven in Part I. | 23b. Did | tobacco uee co Yee 2□ No an eutopsy mned? | ntribute to 3 Prot | Approximata Intervei Between Onset end Deeth US The cause of death? The cause of death? | |
| Be o | examiner? | Hospitel: | TERM | a 🗆 BOA O | thor | | | 46016 | | |
| completely filled in by the funeral director, page 2 Medical Certification: To Be Comp | 27. Manner of Death 1 Platural 5 Pending 2 Accident investiget | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inj | 4 LI Nursing | 28d. Describe | how injury occur | | у) | |
| led in by the funer Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide detarmine | 28f. Location (City or To | | per or Rure | ol Route Number, | | | | | |
| To the Funeral Director: After completely filled in by the funer Medical Certification: | 29a. Cartifier Check only 2 Medical Exp | thysician: To the best of my known in the common three control of the basis of axamina and manner stated. | owledge, death ation and/or inve | occurred at the estigation, in my | time, data and plac opinion, death occ | e, and dua to tha surred at the time, | cause(s) and mi data and placa, | annar as si end due to | tated. o tha cause(s) | |
| Toth | 29b. Signature and title of certifier | | | 29c. Licer | nse number | | 29d. Dete signe | d (Month, | Dey, Year) | |
| | 1 Steen | | | 12-31 | 1868 | | April 19 | 1566 | | |
| | 10 | 055 Lufe Popul | it PIL | Print) Colum | las, mo | 0 21144 | , | , | | |
| State Registrar | 31. Date filed (Month, Dey, Year) APR 2 1 10 | 32. Registrar's Sign | ature | -por | | | | | | |
| - | AFRAIS | The state of the s | | S. Cart. A. | | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNE APRIL 16, 1999 SOPHER 2:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Dey, Year) SEPT 14, 1912 5. Social Security Number Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-05-9267 86 Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ahow infree must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4335 CRESTHEIGHTS RD. 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: "natural", or Nems Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3. Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 8 HOMEMAKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofter any Injury or other traumatic avant place. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 BENDER 2 HYMAN COHEN 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOAN RUDICK / DAUGHTER 1206 KNOLL MIST LANE - GAITHERSBURG, MD 20879 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State RADOMER VEREIN 4/19/99 ROSEDALE, MD 5/☐ Other (Specify) 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE MD 21208 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one states on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Coronary The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a Box 68760. Physician/Medical Due to (or es a consequence of) 980 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Parkindons 1 Yes 2 do 3 Probably 4 Unknown Completed by Division of Vitai Records, lung disense. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate 1 ☐ Yas 2 ☑ No 1 Yes 2 No or Attanding Physician: Be 25. Wes casa refarred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury st Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attandir within 24 hours after death. To the Funeral Diractor: A 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.

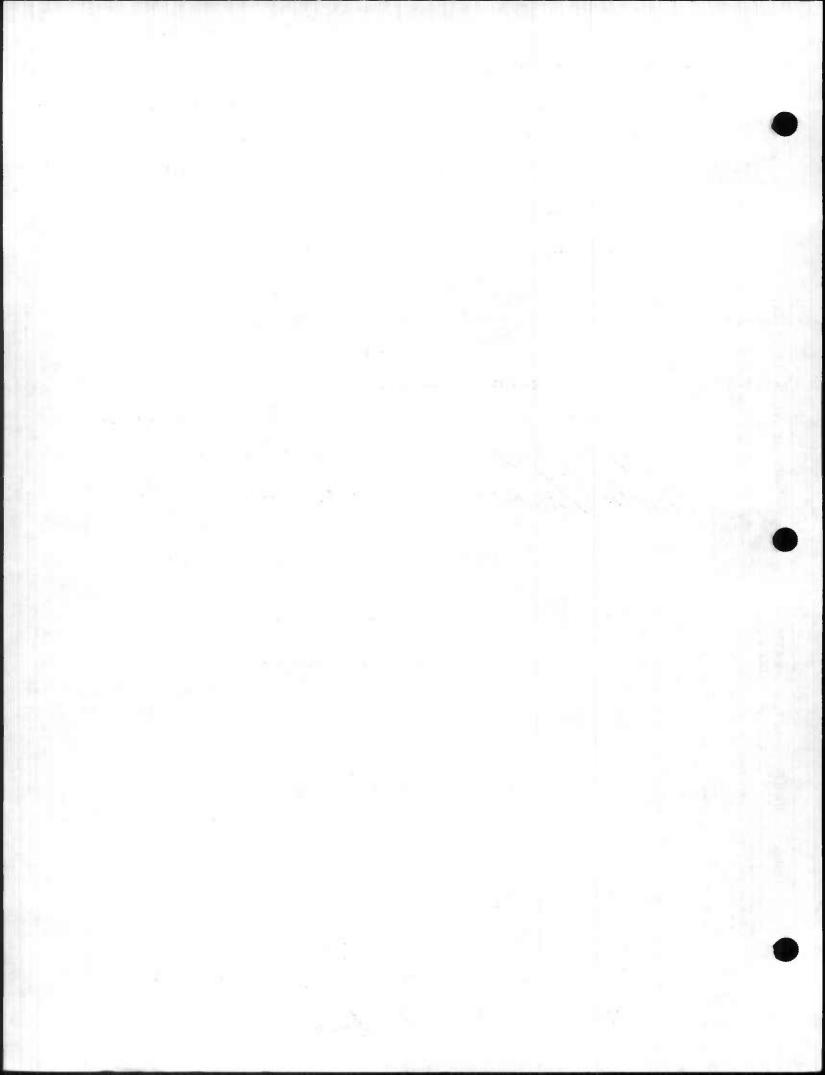
| Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Neme and eddrass of person who completed cause of death (Item 23a) (Type, Print) TER old Court Nd. Baltimore; 4000 31. Date filed (Month, Day, Year) 22 Registrar's Signature State

Registrar **DHMH 16 Rev 6/95**



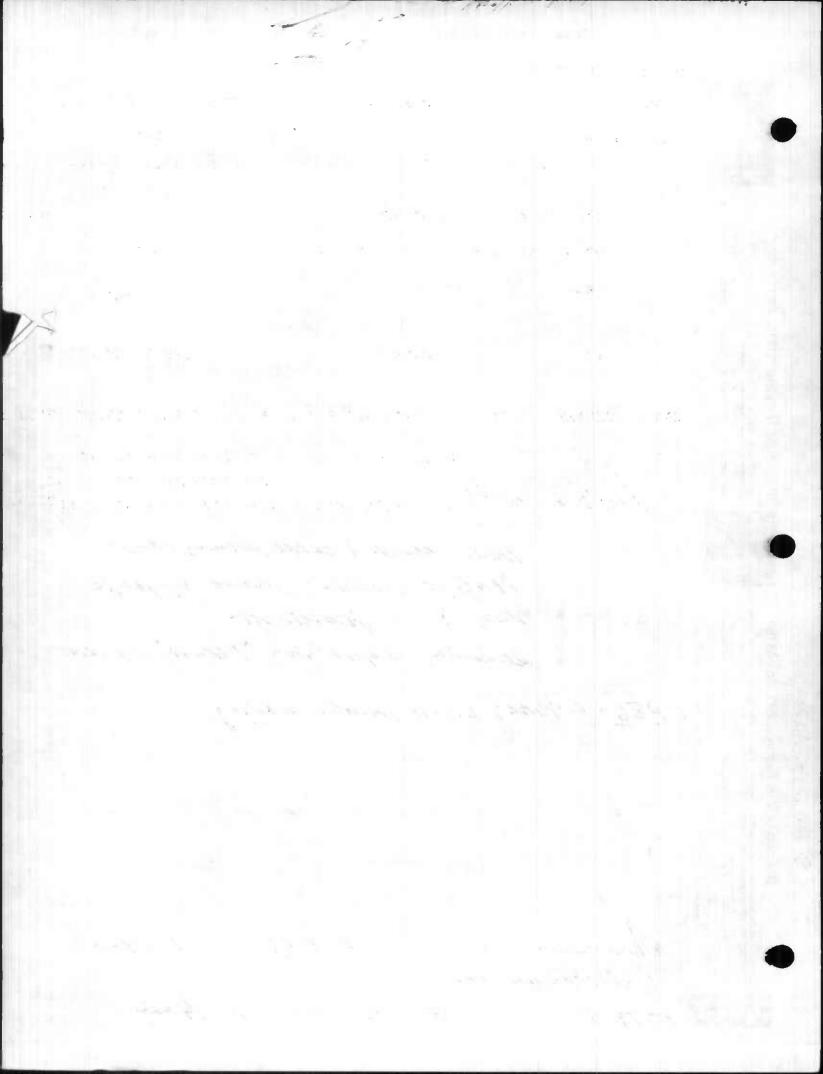
| | Item: 17 per F.H G- | | Maryland / De | epartment of I Certificate of | | Mental Hy | rgiene Reg. No. () () | 10000 | | | | |
|--|--|-----------------------------------|--|--|--|--|---|---|--|--|--|--|
| Physician | 1. Decedent's Name (First, Middle | | | AFRANSKA | | Month | 2. Dete of Death | | | | | |
| /Medical Examiner | 4e Fecility Nama (If not institution 47 TAHOE CIRC | , give street and num | ber) | | | r Location of Dee | th 4c. County | | | | | |
| Funeral Director | 5. Social Security Number 219–35–6407 | 6. Sax 1 ☐ M 2 ☐ F | 7. Age (In yrs. last birtho 83 Yr | Months Devs | | | | Birthplaca (Steta or Foreign Country) UKRAINE | | | | |
| 2 . | Usuel Rasidence of Decedent 10a. Stete 10b. County | | 10c. City, Town o | or Location | | | | 10d. Inside City Limits | | | | |
| Varyta Varyta Ned at | | TIMORE | OWINGS | | | | | 1 ☐ Yes 2 🖾 No | | | | |
| von the Me t or 28e-f s be notified Director | 10e. Street and Number | 11.101115 | OWINGS | 10f. Zip Code | - | | 10g. Citizen of V | /hat Country? | | | | |
| | 47 TAHOE CIR | CLE, APT. | В | | 21117 | | U.S.A. | | | | | |
| 020 ars after death virt, or terms 23 Daminer ment by Funeral | 11. Marital Stetus 1 □ Never Merried 2 □ Marr 3 ☑ Widowed 4 □ Divorced | Armed For | 2 No | Wes Decedent of If Yes, specify Cub Yes 2√√No | | (Specify Yas or Ne erto Rican, etc.) | Blec | e - American Indian, k, White, etc. WHITE | | | | |
| 1 21215-0020 ad within 72 hours at your than "natural", or it, the Medical Exam Completed by I | 15. Deceden (Specify onfy highes Elementery/Secondary (0-12) | t grede completed) Collega (1- | 4or 5+) | ecedent's Usuel Occu Give kind of work done fe. DO NOT use retire | during most of w | rorking | nking 16b. Kind of Business/Industry | | | | | |
| | 17. Fathar's Name (First, Middle, | Last) | EMBR | OIDERESS | 18. Mother's N | eme (First, Middle | ART | a) | | | | |
| yland build be fi Mental H Mental H Mental H Mental H To Be | PASKAL | CHERNYA | K CHERN | HAK | SONYA | omo (r mot) moon | , | FINKELSTEIN | | | | |
| Maryland d 2 should be fine th and Mental Hy T le menthed othe treatments event | 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z | | | | | | | | | | | |
| 4 5 5 6 7 | POLINA SHAFRA | NSKAYA / D | | TAHOE CIR | CLE #B | | | | | | | |
| Saftimore emit. Pages 1- separtment of He important if Neu iny Injury or oth inter | 20a. Method of Disposition 20b. Plece of Disposition (Name of cemeter), cremetory or other place) 20c. Location - City or Town, State 20c. House of Detection - Cit | | | | | | | | | | | |
| aftin | BALTIMORE HEBREW CEMETERY 4/18/99 REISTERSTOWN, 21. Standard of Funday Service Date of Feelility SOL LEVINSON & BROS., INC. | | | | | | | | | | | |
| Be per per per per per per per per per pe | NIMINT | Druger | / | | | | | LE, MD 21208 | | | | |
| Physician /Medical Examiner | 23a Part Enter the disease or shock or heart failure. List Immediate Cause (Final disease or condition | | used the deeth. Do not ch line. LEW CLARL M Due to (or es e co | | | ec or respiretory (| errest, | Approximete Interval Between Onsat and Death | | | | |
| | resulting in death) | 0 | Due to (or es e cor | nsequence of): | | | | | | | | |
| executed in end interest | | b. Coron | Due to (or es e con | my dree | es | | | | | | | |
| | Sequentially list conditions, if any, leeding to Immadiete ceuse. Enter Underlying Ceuse (Diseese or injury | Lea | neuteune. | | reulai | / disee | ens | 1 1 1 1 1 1 1 | | | | |
| | that initieted events resulting in death) Last | C | Due to (or es a cor | | 200 00 | | | | | | | |
| Box 68 eath certifica attending ph for use as t | | d. Seva | we Conor | re ols frue | In De | lucren | dises | | | | | |
| death cert death cert e attendin ed for usa | Pert II. Other significant condition | | | | A | | | ntribute to the cause of death? | | | | |
| P.O et the et the etache | Total agrillount contains | THE CONTINUOUS TO GOE | veri iii r ent i. | 1 Yes 24 No 3 Probably 4 Unknown | | | | | | | | |
| by bed by | | | | | | - | - | | | | | |
| or requ hoult | | | | | | | s an autopsy ormed? | 24b. Were autopsy findings available prior to completion of ceuse | | | | |
| | | | | | | 10 | Yes 2 No | of death? | | | | |
| f Vital Resident The la director, page | 25. Wes cese referred to medical | | - | | 26. Plece of D | eeth (Check only | | TEL TOS ZENIO | | | | |
| Of Vital Physician: Tribis certificate rel director, pr | exeminer? | Hospital: 1 □ In | patient 2 ER/Outpo | atient 3 DOA Ot | hor: | Home 5 Res | | ar (Specify) | | | | |
| Ing Ph Wher th unerel | 27. Mennar of Death 1 Naturel 5 ☐ Pendin | | Injury 28b. Tim Dey Year) Inju | ry Wo | | 28d. Describe | how injury occurr | ed | | | | |
| Division or To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ | ot be 28e. Plece of | of Injury - At home, ferm g, etc. (Specify) | | Yes 2□No | | (Street and Numb wn, State) | er or Rurel Routa Number, | | | | |
| Detal o | 29e. Certifler | Dt. 1-1- T at 1 | | | | | | | | | | |
| To the Hospital within 24 hours To the Funeral completely filled Medical C | | Examiner: On the bas end menne | est of my knowledge, d sis of examinetion and/o er steted. | eem occurred at the tile in investigation, in my o | me, date end pla- opinion, deeth oc | ce, and due to the curred at the time | , dete end plece, a | and due to the ceuse(s) | | | | |
| To the vithing comp | 29b. Signeture and title of certifier | D. | | 29c. Licens | | | 29d. Date signed | 1 (Month, Day, Year) | | | | |
| | tavid |). Kenin | W) | | 428 | | 4/16/ | 29. | | | | |
| | 30. Name and address of person | who completed cause | of death (Item 23a) (Ty | rpe, Print) | GIO DIL | esule 1 | MD 212 | DR. | | | | |
| State | 31. Dete filed (Month, Day, Year) | 32. Re | Signetura | 00000 | 010 (110 | - OI IFV | W 0116 | 4 5 | | | | |
| Registrar | APR 2 0 | 1999 | Geneva | 4 loo | 11 | | | | | | | |

AH



| | | | Item:31 per V.R G-77 | 0 4/21/99 reb | | epartment of I Certificate of | | | Reg. No. | | 3061 | |
|---------|---|---------------------------------------|---|---|--|--|--|--|--|--------------------------|---|--|
| | | sician edical | Decedent's Name (First, Middle, AARON | Last) | SCHV | VARTZ | | 2. Date of De Month APRIL | _ | ġ g′9 | 3. Time of Death | |
| 4 | | miner | 4a Facility Name (If not Institution, LEVINDALE | | | | 4b. City, Town, or L BALTIMO | ORE N/A | | | | |
| | Funer Direct | | 5. Social Security Number 215–12–3310 Usual Residence of Decedent | 6. Sex 7. A | ge (In yrs, last birti 82 _y | hday) If Under 1 Year Months Days | Hours Min. | 8. Date of Bi | * 1 1916 | 9. Birthp | Birthplace (State or Foreign Country) POLAND | |
| | with the Maryland a or 28a-f show | tor | 10a. Stete 10b. County MD BALTI | MORE | 10c. City, Town | | | | | 0d. Inside City Limits | | |
| | ath with the Marylan 23s or 28s-f show | al Director | 10e. Street and Number 2215 WOODBOX | LANE API | ·.C | 10f. Zip Code 21209 | 9 | | ntry? | | | |
| | tar dae | by Fune | 11. Maritel Status 1 Never Married **CMMarrie 3 Nidowed 4 Divorced | 12. Wes Decedent Armed Forces' ad 1 X Yes 2 ☐ If Yes, Give Year or Dates: | ? | 13. Was Decedent of I If Yes, specify Cub | | Specify Yes or No- rto Rican, etc.) 14. Race - American Indien Black, White, etc. SpecifyWHITE | | | etc. | |
| | 215-0 hin 72 ho in "natur Modical | pleted | 15. Decedent' (Specify only highest Elamantary/Secondary (0-12) 1 2 | usiness/inc | | | | | | | | |
| | re, Maryland 21. 1 and 2 should be filed with tem 27 is marked other tha other traumatic event, the | To Be Co | 17. Father's Name (First, Middle, L MENDEL | ast) | SCHWAR | ZBAUM | 18. Mother's Nam EVA | ne (First, Middle | RETAIL Maiden Sumam KAMINS | 10) | DIT | |
| | Mary and 2 shou aith and N | - | 19a. Informant's Name/Ralationsh SARAH SCHWART | | 19b. 22 | Mailing Address (Street WOODB) | t and Number or Rus | APT. (| per, City or Town, | State, Zip MORE | Code) E,MD 21209 | |
| | Baltimore, M pemit. Pages 1 and 2 Department of Haailh a important: if few 27 is any lojury or other tra | ry or othe | 20e. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | cemeter | Disposition (Nama of c, crematory or other pla V YOUNG MI | | Date /15/99 | 20c. Location - WOODL | | | |
| C | Geath cartificate be assected by the death cartificate be assected by the death of for use as the bunal-transit of for use as the bunal-transit | a a a a a a a a a a a a a a a a a a a | 23a. Part1. Enter the disease, or o shock, or heart failure. List of the shock of heart failure. List of the shock of the | Bluce. | Due to (or as a concept of the conce | onsequence of): Creffer it onsequenca of): Plus onsequence of): Dyples | sediop ; Sev feiroco ssion, | euse V hes | Dysph Lic a | es L agis | Onset and Daath | |
| 2, Aaro | cords, P.O v requires that the been signed by th should be detache | leted by | Part II. Other significant condition | se contributing to death I | _ | Musical American Care of the Control | | 24a. Was | | 3 Pro | o the cause of death? Ibably 4 Unknown Vare autopsy tindings (allable prior to mpletion of cause death? | |
| wart | f Vital ysician: The ysician: The ysician: The ysician director, pa | To Be | 25. Was cese referred to medical examiner? 1 ☐ Yes 2 ⋈ No | Hospital: | ient 2 ER/Out | patient 3 DOA Ot | 26. Placa of Daa ther: 4⊠Nursing H | th (Check only | Yes 2 No ona) idence 8 □Oth | | □Yas 2□No | |
| Schwart | Division o To the Hospital or Attending Ph within 24 hours after death. To the Funerst Director: After th complataly filled in by tha funarel | ertification: | 27. Manner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investig 6 Could n determin | ot be 28e. Piace of In | ay Year) In | ijury Wo | Yes 2 No | 28f. Location | how Injury occur (Street and Numb wn, State) | | al Route Number, | |
| | n 24 hours Funerst | edical C | 29a. Certifier 1 Certifying (Check only one) 2 Medical E | Physician: To the best xaminer; On tha basis of and manner s | of my knowledge, of examination and tated. | death occurred at the ti | ime, date and place, opinion, daath occur | , and due to the rred at the time | causa(s) and ma , date and piace, | annar as s and dua to | itated. o tha causa(s) | |
| 4 | To the To the Comp | M | 29b. Signal and titla of certifier | | 6 | | 4363 C | 0 | 29d. Date signe | | | |
| 8 | 1 | | Te . | softa r | 0 | Type, Print) | | | | | | |
| 7 | Regi | State Istrar | 31. Date filed (Month, Day, Year) | 32. Ragist | rar's Signature | 0 1999 | Beneva | B. , | Sparks | / | | |

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** en Anne /Medical a. Facility Name (If not Institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Deeth Examiner Baltimore HOS Pita tf Under 1 Year If Under 24 Hrs. 5. Social Security Number # Hirthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 214-30-4899 Deys 1□M 2♥F Yrs. Director Usuel Restdence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore m 1 Yes 2 No Director 10e. Street end Number 10g. Citizen of What Country? ò 22 items 23a Funeral 12. Was Decedent Evar in U,S Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cubas, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Maritai Status 1 Never Merried 2 N Marriad 1 ☐ Yes 2 No ò Baltimore, Maryland 21215-0020 If Yas, Give Yeer or Detes: 1 Yes 20 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Peges 1 and 2 should be filed withit Depertment of Health and Mental Hygiena. Important: If Itam 27 is marked other than any Injury or other traumest. College (1-4or 5+) Elementery/Secondary (0-12) Government 17. Father's Neme (First, Middle, Last) Mother's Neme (First, Middle, Maiden Sumeme) Wesley telen 19b. Mailing Address (St 423 20b. Place of Disposition (Name of company, crematory or other 20e. Method of Disposition Town, Stete 1 ☐ Buriel 2 ☑ Cramation 3 Removel from Stata 4 Donation 5 Doner (Specify) Funeral S Ambrose Home Sul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heer feilure. List only one ceuse on each tine. Approximata intervel Betw **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or trijury that initiated events resulting in death) Lest end Due to (or es e consequence of): Physician/Medical the Due to (or es e consequence of): for usa es signed by the id be detached Pert tt. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings aveilabla prior to completion of causa of death? 24e. Wes an eutopsy performed? page 2 this certificete 2 3 No 1 Yes NAME Division of Vital director, 25. Was case referred to medicat exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Restdenca 6 Other (Specify) 20 No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA eral Director: After this 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how tnjury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturet daath. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of tnjury - At home, farm, street, lactory, offica building, etc. (Specify) after 4 Homicide Hospital or To the Hospital of within 24 hours at To the Funeral D completely filled edicai 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and pteca, end due to the cause(s) end menner es atated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end ptece, end due to the cause(s) end menner steted. 29e. Certifier (Check only 29b. Signature and title of certifies 29c. License number 29d. Data signed (Month, Dey, Year) 120

State Registrar

a 31. Dete filed (Month, Dey, Yeer)

14. Scrubbs MD 900 h, Dey, Yeer) 32. Registar's Signature

d cause of death (Item 23a) (Type, Print)

Gaton Armue Baltimore Maryland

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Registrar

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30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

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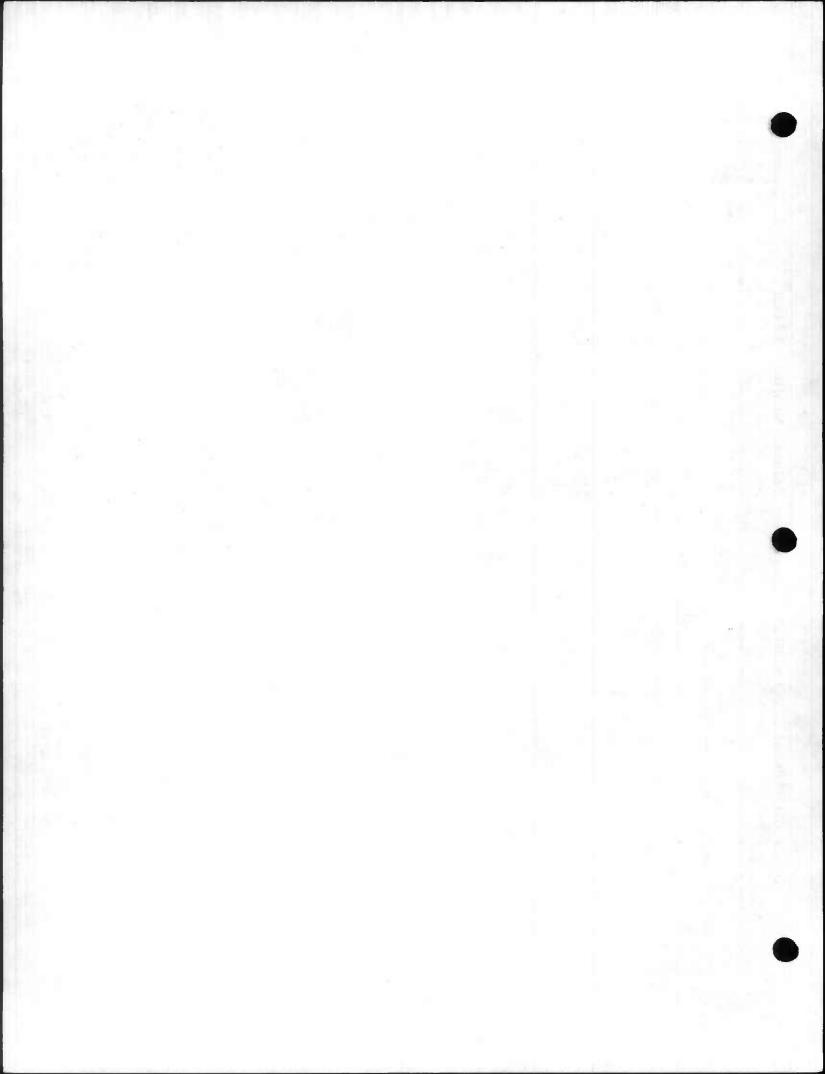
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32. Registrar's Signetura

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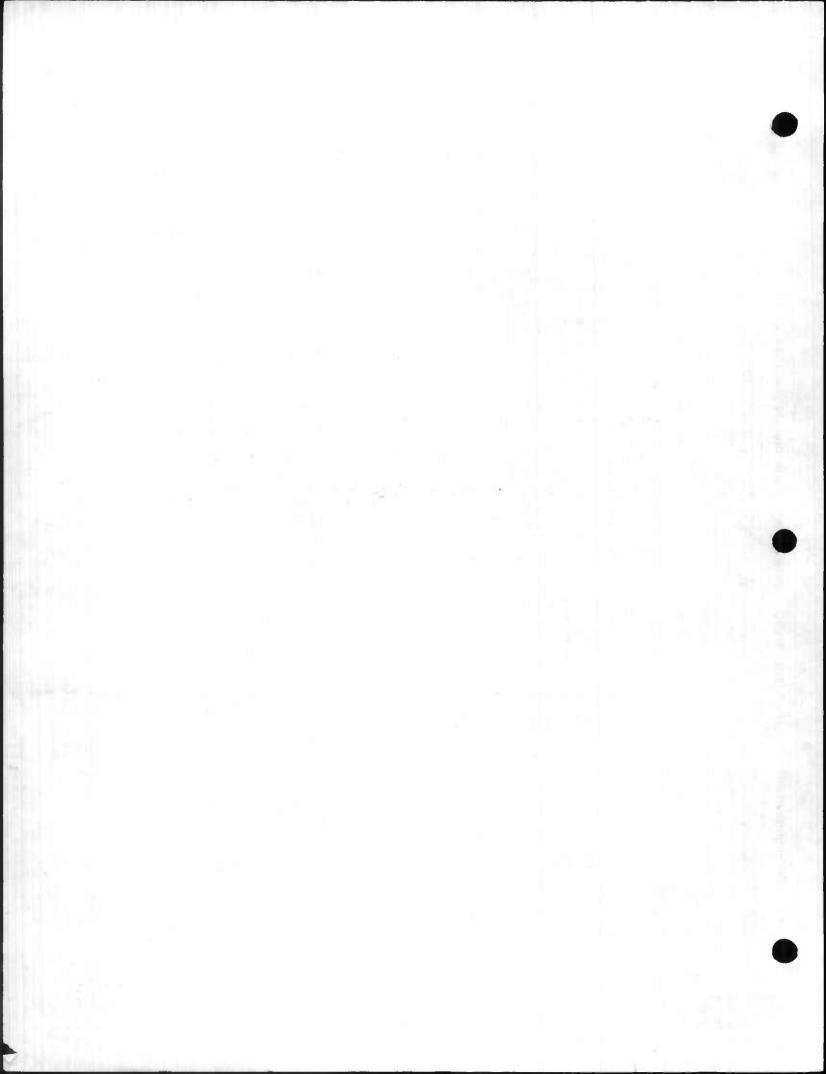


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Dev Month **Physician** Sakowski Gertrude 8:30am 20, 1999 April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Annapolis Blvd. Linthicum, MD Anne-Arundel If Under 24 Hrs. Hours | Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 215-10-3165 DOM 20 F 82 Yrs. Director April 8,1917 CT Usual Residence of Decedent the Maryland 10b. County 10a Slete 10c. City, Town or Location r 28a-f show 10d. Inside City Limits 1 Yes 3 No MD Director Anne-Arundel Linthicum Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? w 23a or 21090 United States 6868 Baltimore Annapolis Blvd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int. if Hem 27 is marked other than "natural", or its ary or other traumatic event, the Medical Examines. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 3 Merried 21215-0020 White 1 Yes > No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Phone Company Telephone Operator 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Harry Linton Barese Anna 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6868 Baltimore Annapolis Blvd. Linthicum MD 21090 Elmer A. Sakowski / Husband 20a. Method ol Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of important: If any injury or Crownsville Veterans Cametery | April 23,1999 Crownsville Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, Maryland 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical 4 COVI Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Pug Due to (or as a consequence of) Box 68760, Physician/Medicai the Due to (or as e consequence of) for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contributa to the cause of death? ronde obstructive lung disease 1 1 708 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy lindings aveilable prior to completion of cause ol death? congestive heart failure 24a. Wes en autopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home STResidence 6 Other (Specify) Certification: To 1 Yes 2€No 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Qetural To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 022782 April 20, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Honover St. Dal/Imore, Md, 21230 erkman w 3 001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 1 1999

DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 23 part I,per M.D G-770 4/20/99 reb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Stevenson Mar Jeora /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Church Home Hospital Balto N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Deys Hours Min. Apr 11, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 10XM 20 F Yrs. 76 1922 214-18-8091 ÓH Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinal must be notified at 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 Nes 2 No Balto Director 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1300 E. Lanvale St Aot 512 21213 Funeral U.S.A. 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 20 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Merried Specify: Black 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Florist 6th TRUCK DRIVER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George Stevenson Sr Geneva JOhnson 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Brenda Marrett/daughter 647 Haven P1 Edgewood, Md 21040 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Important: If its eny injury or o once. *DBuriel 2 Cremation 3 Remove from State Baltimore Cem 3-17-99 Balot, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral HOme 1129 N. Caroline st Balto, Md 23a. Perfi. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21213 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) tion minutes Examiner Due to (or es e consequenca of): Physician/Medical Examine RENAL FAILURE physician and the bunal-transit The law requires that the death certificata be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, CHRONIC PULMONARY DISEASE Due to (or es e consequence of) 50 usa signed by the a d be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evalleble prior to 24e. Wes an autopsy performed? Completed completion of ceuse of deeth? cartificate has to lirector, page 2 s 2 No 1 Yes 2 No Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) To F 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Aftar this funeral 28e. Date of Injury (Month, Day Year) 27 Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Naturel 5 Pending investigation n 24 hours after death.

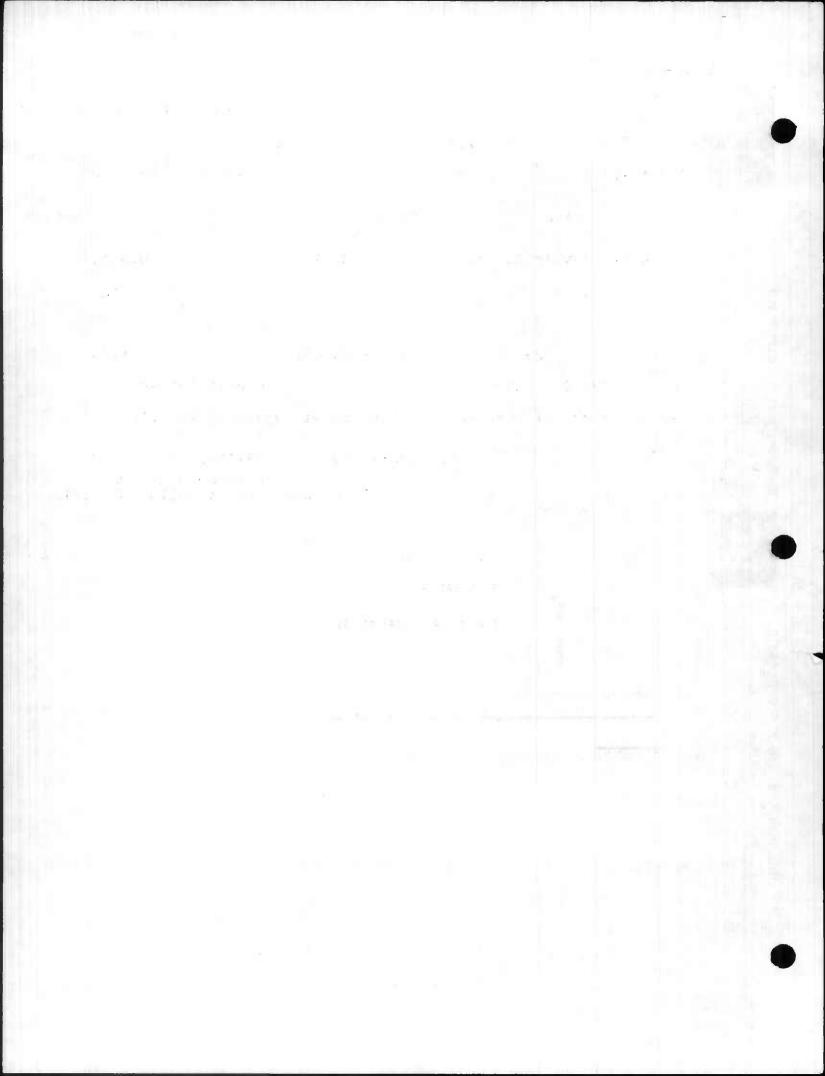
Funeral Director: After the function of the function 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 29e. Certifler Descritifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completaly fi Medical (Check only one) 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signature and little of ogriffer 29c. License number

(Item 23a) (Type, Print)

baltimore MIS 2/229

State Registrar GOLMIEN.

31. Dete filed (Mag



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 23 part I 27 28a-f per MEO G-769 3/4 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death 21, 1999 FEB. 7:42 AM

Physician · /Medical Examiner

Donald Earl Tittle 4a Facility Nama (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

Funeral

Director the Maryland

item 27 is marked other than "natural", or items 23s or 25s-f show other traumstic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death on and Mental Hygiene.
Is marked other than "natural", or items 23s permit. Peges 1 end 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physician end Physician/Medical 80 USe signed by t Completed by peen has page 2 After this certificate director, Be Certification: To funeral

certificata be executed or Attending Physician: eftar death To the Funeral

Division of Vital Records, P.O. Box 68760,

| 3037 NORTH ROLLING ROAD | | | | | | | | | WOOD | LAWN | | BALTIMORE | | | |
|--|----------------|-----------|-----------------|------------------------|--------------|-------------|-------------|-----------------------|-------------------|---------------------------------|-------------------|-----------------------------|---------------------------|--|--|
| 5. Social Securify Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Y | | | | | | | | | If Undar Hours | 24 Hrs. 8. | Date of Birt | h Veer) | 9. Birthplaca | Birthplaca (State or Foreign | |
| 548-96-4 | 4100 | 10 | 1 □ ¥M 2 □ F 42 | | | Yrs. | MONITS | Days | Hours | 02 | /26/I | 956" | Callif | ornia | |
| Usual Residenca o | f Decedent | | | | | | | | | | | | | | |
| 10a. Stata | 10b. Count | * | | 1 | | Town or Lo | | | | | | | 10d. lr | side City Limits | |
| MD | Bal | timo | re | | Cat | onsvi | lle | | | | | | 1 | ☐ Yas 2 No | |
| 10e. Street and Nu | mber | | | | | | 10f. Zip | Code | | | | 10g. Citizen of V | What Country? | | |
| 709 Ferr | Vall | ev C | ircle | | | | 2.1 | 1228 | | | | U.S | .A. | | |
| 11. Marital Status | | -) - | 12. Was Dec | edent Eva | ar in U.S. | 13. V | Vas Dece | dent of H | lispanic Or | igin? (Specif | v Yes or No- | 14. Rec | e - American In | dian, | |
| 1 Never Marr | ind OFTH | anla d | Armed F | orces? | | 1 | Yes, spe | city Cubi | an, Maxice | igin? (Specifi n, Puerto Ric | an, etc.) | Blac | ck, White, etc. | | |
| 3 Widowed | | | If Yes, G | 2 KNo ive Datas: | | | ☐ Yes | 2X No | Specify. | | | Specify | . White | | |
| | 15. Decede | ent's Edu | | | | 16a. Deced | lent's Usu | al Occup | ation | | 1 | 16b. Kind of B | usiness/Industry | , | |
| | cify only high | est grad | le completed | | | (Give | kind of wo | ork done se retire | during mos | at of working | | | | | |
| Elementery/Seco | ondery (0-12) | | College | 1-4or 5+) | | Land | scape | er | | | | Lawn | Mainta | ince Co. | |
| 17. Father's Name | (First, Middle | e, Last) | | | | | | | 18. Moth | er's Name (F | irst, Middle, | Maiden Sumen | | | |
| Richard | Deane | Tit | tle | | | | | | Dor | othy E | Eileen | Kocka | | | |
| 19a. Informant's N Dorothy | _ | | ype, Print) | | | | | | | | | or, City or Town, Nevada | | 9) | |
| 20a. Method of Dis 1 Burial 2 4 Donation | Cremation | | | | | a of Dispo | | | atory | | Date 25/99 | 20c. Location - Laurel, | City or Town, S Maryla | | |
| 21. Signature of Fu | lyn | 2 | Ble | Le caused th | e death | 6 | 415 | Bela | ir Ro | ad Bal | timor | ller In e, Mary | land 21 | 206 | |
| Immediate Cause | (Final | st only o | | | | ICATIO | | | | | | | Inte | rval Between et and Death | |
| resulting in death) | 211 | | a. NANC | | | s a conseq | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Conventielly list on | n distant | | b | Du | e to (or a | s a conseq | uence of | , | | | | | | | |
| Sequentially list co if any, leading to in | nmediate | | | | .0 10 (0. 0. | 0 4 0011004 | u 01100 017 | | | | | | | | |
| cause. Enter Under Cause (Disease or that initiated event | rinjury | < . | c | | | | | | | | | | | | |
| resulting in death) | | | | Du | e to (or as | s a conseq | uance or): | | | | | | | | |
| | | C. | d | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Part II. Other signi | ficant condit | tiona cor | ntributing to | leath but r | not resultin | ng In the u | nderlying o | cause giv | en in Part | l. | | | | cause of death? | |
| | | | | | | | | | | | 1 🗆 | Yss 2□No | 3 Probably | 480nknowr | |
| | | | | | | | | | | | 24a. Was perfo | an autopsy | availabl | utopsy findings e prior to tion of cause | |
| | | | | | | | | | | | 102 | res 2 No | 1 Yes | 2 No | |
| 25. Was case refer | rred to medic | al | | | | | | | 26. Plac | e of Death (C | Check only o | one) | | | |
| examiner? | No | 1 | Hospital: | Inpatient | 2 🗆 EF | VOutpatien | t 3 D | OA Oth | ier: 4 🗆 N | ursing Home | 5 Resid | dence eXoth | ar (Specify) A | T SCENE | |

29a. Certifiar (Check only one) Medical

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

**Continuous of the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated.

28c. Injury at Work?

1 Yes

2 No

29b. Signatura and thia of certifia

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 - Homicide

29c. Licanse number O.C.M.E

29d. Data signed (Month, Day, Year) 22, 1999 FEB.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 709 Fern Valley Circle

Other: 4 Nursing Home 5 Residence of Other (Specify) AT SCENE

28d. Describe how injury occurred

UNKNOWN

ted cause of deeth (Item 23e) (Type, Print) 1050

111 Penn Street, Baltimore, Maryland 21201

State Registrar Month, Day, Year) MAR 4 1999

5 Panding Investigation

€XXX Could not be determined

32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

UNKNOWN, found at home

28b. Time of

Unk.

28e. Placa of Injury - At home, farm, street, factory, offica bullding, etc. (Spacify)

injury

28a. Date of Injury (Month, Day Year)

found 2/21/99

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Yaar **Physician** V. Anna Thompson 1:30pm 18, 1999 April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie, MD Anne - Arundel If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) March 29, Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 125}F 89 Yrs. 216-28-3589 1910 Director MS **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show N/A MD Baltimore City Director XXYas 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1437 Reynolds Street 21230 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? thems. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 M Mo If Yes, Give Year or Dates: 1 Never Married 2 Married b 21215-0020 1 ☐ Yes 文♥ No Specify: White þ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be if of Health and Mental If Rem 27 is marked o George Webster Mary Janis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Constance J. Hooper / Daughter 208 Northway Road, Reisterstown Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 8 to Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If 1999 Holy Cross Cemetery April 21, Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
Charles L. Stevens Funeral Home, Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the leads. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each limit. Approximata Intarval Batwe Onsat and Daath **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Ceresionentar acciden Examiner Due to (or as a consequence of): Examiner zent er The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably H120PHNENIA þ Division of Vital Records, ate hes been sign page 2 should be 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed'i this certificate hes 1 Yes 2/2No 1 ☐ Yas 2 ☐ No funaral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other Stationary Stationary Stationary Other (Specify) 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deett 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t ours after deen.

*I Director: An.

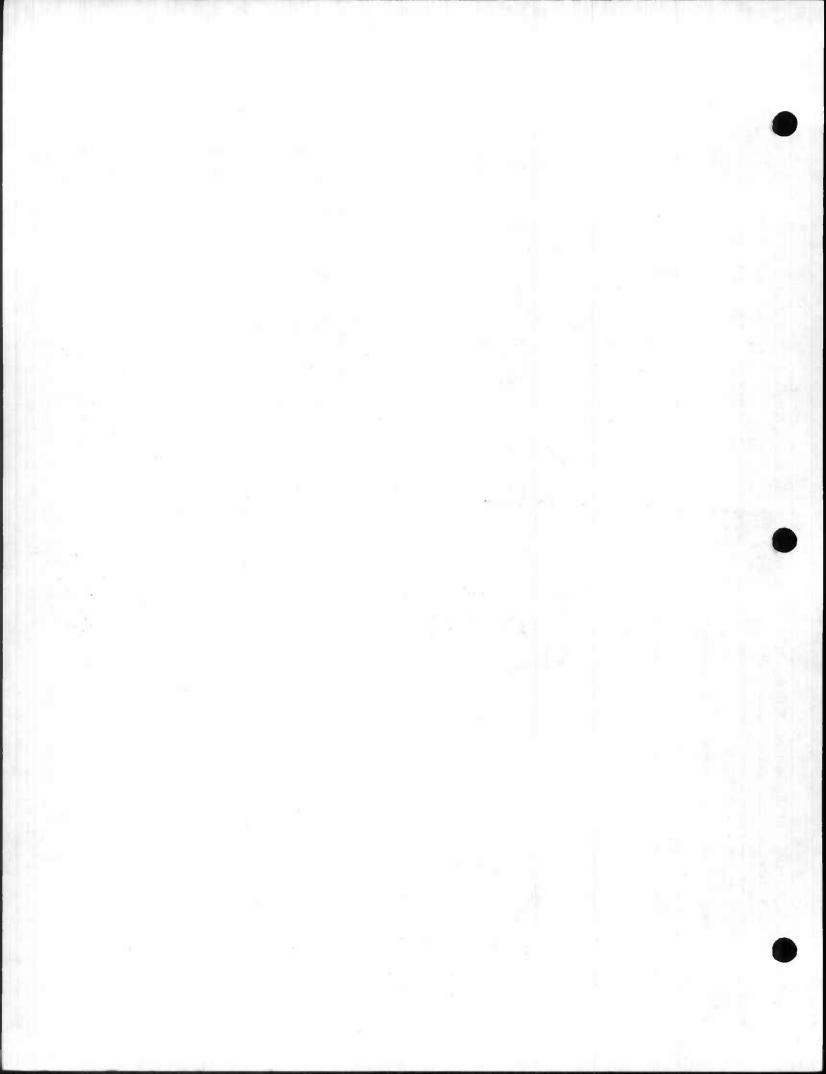
'in by the fur-Attanding ★Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and msnnar as ststed.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only iner: On the basis of axa and manner stated. 29b. Signature and title of contiller 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 1999 Registrar

DHMH 16 Rev 6/95

10

ORIGINAL



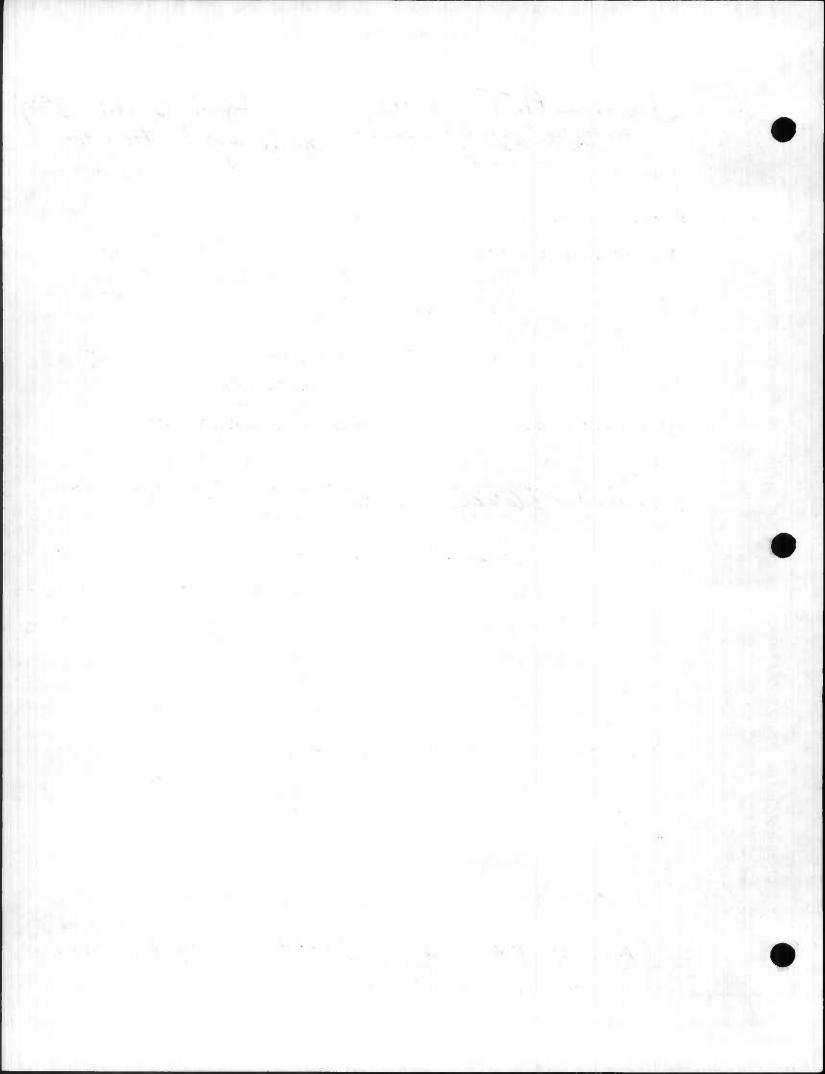
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death Date of Deat **Physician** 4b. City, Town, or Location /Medical Examiner Chyma OW) ack If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Nur **Funeral** Deys Yes 86 Director 288-14-3655 3,1913 Rhode Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County "natural", or items 25s or 28s-1 show 1 ☐ Yes 2 No Howard Ellicott City Maryland Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3004 Northridge Road #335 21043 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 2 No If Yes, Give Yaer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white À 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16h Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) 12 Induction Heating 4 Electrical Engineer is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Pages 1 and 2 should be nent of Health and Mental Chester Wilson Tudbury Bessie Anthoine 2 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Separtment of Health mportant: If Nem 27 Martha Hamill/daughter 8622 Hayshed Lane/Columbia, MD 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 M Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licanses 22. Neme end Address of Facility Ronald S. **Director** Wade State Anatomy Board, 655 W. Baltimore Street Meile an Baltimore, Maryland 21201 23a. Flart 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner ettending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, + pentension Due to (or es a consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed Degenerative Toint disease certificate has b lirector, page 2 s 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Neturel 5 Pending Investigation n 24 hours after death.

Ne Funeral Director: Al pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, straat, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the cause(s) and menner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) end menner stated. 29a. Certifie To the Hosp within 24 hos To the Fune completely fi edical (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) no completed cause of deeth (Item 23e) (Type, Print) 30. Neme end eddress of person National Pike, Fllicott City mg 2/043 8492 Balton ne 027

State Registrar 31. Date filed (Month, Dey, Year)

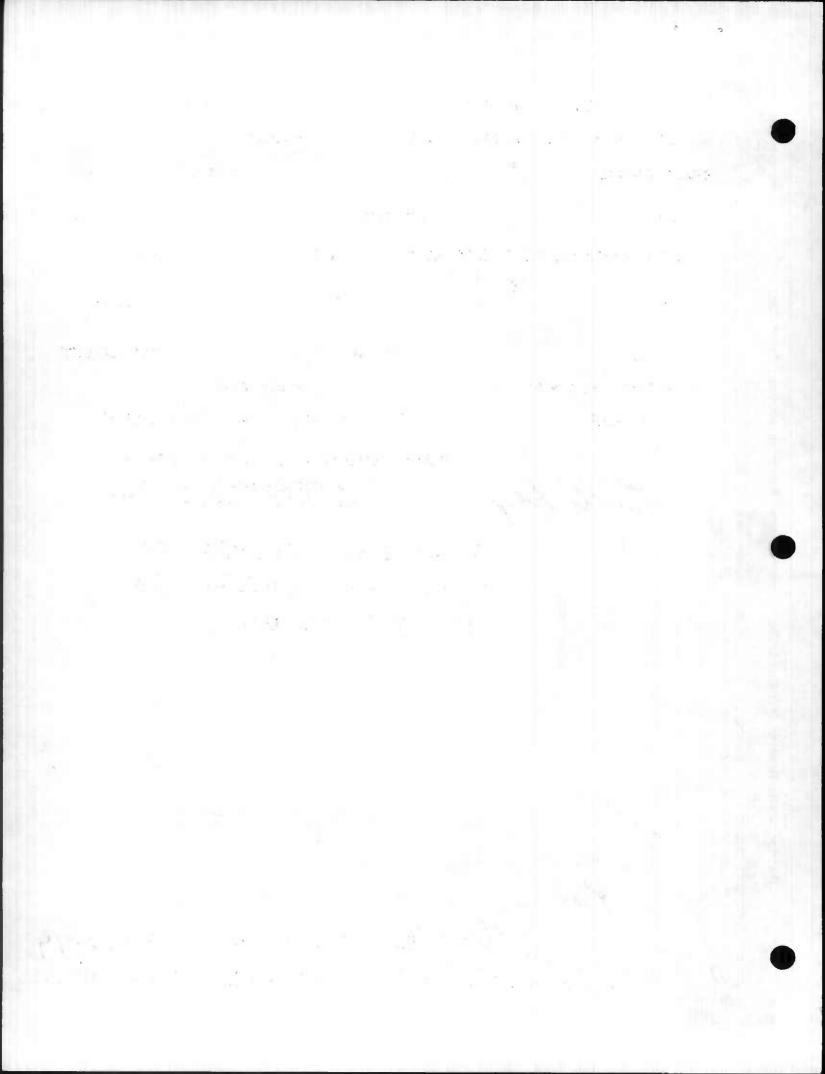
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 4/18/99 **Physician** MARIE E. WIGGINS 10:20 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** 301 McMECHEN ST. APT. 615 21217 BALTIMORE If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2#F Months Days Hours 3/10/10 MD 215-03-6218 89 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Modical Examines must be notified at 1 ☐ Yes 2 ☐ No MD. Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (APT. 615) 301 McMECHEN ST, 21217 21217 USA Funerai death 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Peges 1 and 2 should be filed within 72 hours after d Department of Health and Mantal Hygiane. Important: If itsm 27 is marked other than "natural" any injury or other traumatic even. Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) CLEARK 12 CIVIL SERVICE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CLARENCE F. GORDON CARRIE BOYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CLARA PARKER 2726 N. ROSEDALE ST. BALTIMORE MD. 21216 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊞ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATINOAL CEM. 4/22/99 LAUREL MD. 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funeral Service Licanses 1300 EUTAW PL. BALTO. MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** YOCARDIAL
Due to (or as e consequence of): tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner OROHAR! Examiner physicien and s the buriel-transit certificata be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Physician/Medical 98 950 ŏ 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen has 2 No 1 Yes 2 No 1 ☐ Yes cartificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartific. director 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 0 funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Injury 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homlcide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Cartifier Wedical (Check only one) completely aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. To the I within 2 29c. License number 516 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartified 30. Name and eddress of person who co npleted cause of death (Item 23a) (Type, Print) SETON DR-BALT. ATON 32. Registrar's Signature State new Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month Grace L. Warns APRIL 1999 10:12 AM 4e. Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore | H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth | Month Day, Year | June 12 1921 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1□M 2□F 77 Yrs 216-12-0696 Maryland Usuel Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9110 Lamaze Rd. 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) D'Anglo Salvatore Cincotta Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Andrew J. Warns/Husband 9110 Lamaze Rd. Baltimore, MD. 21234 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 Donation 5 Other (Spacify) Entombment Dulaney Valley Cemetery 4-19-99 Timonium, MD. 21. Signeture of Funeral Service Licer 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Pert LEnter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feilure. Let only one cause on each line. Approximate Interval Between Onset and Death MULTI-SYSTEM ORGAN FAILURE Immediete Ceuse (Final 5 DAYS disease or condition resulting in deeth) Due to (or as a consequence of) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 20 YRS Due to (or as a consequence of): Due to (or es e consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 2 X No 25. Was case referred to medical examiner?

Physician /Medical Examiner

the attending physician and hed for use es the buriel-transit

signed by

peen page 2 s certificate has

To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this

filled in by

8

Be

2

Certification:

Medical pletely

98

be exacuted

Box 68760.

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funeral

Director

r is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

I Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Ihen 27 is marked other any Injury or other traumatic event.

altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Physician/Medical þ Completed

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier

31. Date filed (Month, Dey, Year)

1 Yes 2 No

27. Manner of Death

1 Natural

3 Sulcide

29a. Certifier

4 Homicide

(Check only one)

2 Accident

29c. License number

29d. Dete signed (Month, Day, Year)

lever W. Cho, MID.

5 Pending investigation

6 Could not be determined

D41129

4.17.99

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

PETER CHO, M.D., 7505 OSLER DRIVE, S-306, TOWSON, MARYLAND

Registrar

APR 2 1 1999



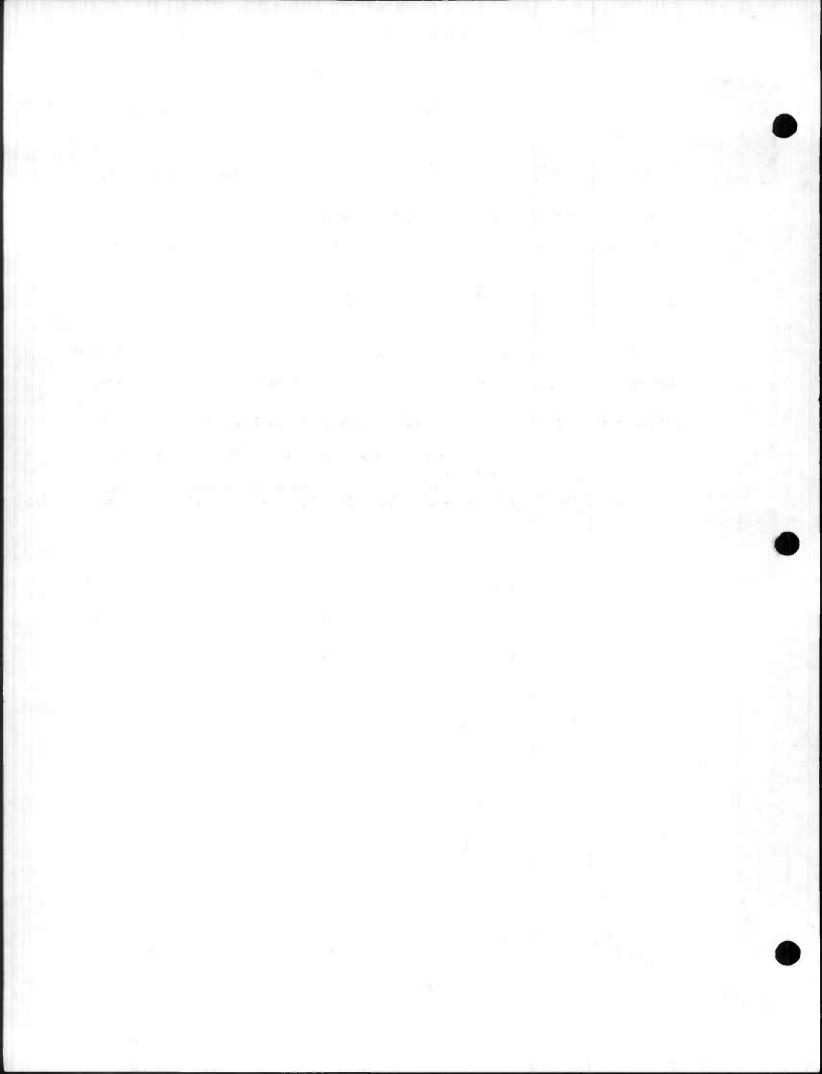
State of Maryland / Department of Health and Mental Hygiene

| | | Decedent's Nama (First, Middle, | Loot | | Cer | tificate d | of Death | 10.000000 | Reg. No. | 1 1 0 |))) | |
|---|------------------|--|---|-------------------------|--------------------------|---------------------------------|---|--|---------------------------------|--|--|--|
| Physic | | John Thomas | 2. Date of D Month | Dev | Yaar 999 | 3. Time of Death | | | | | | |
| /Medi Exami | | 4e. Fecility Nama (If not institution, | | | 4b. City, Town, or | | | | 11:25 PM | | | |
| Exami | ner | Saint Joseph | | | er | | Tows | n | E | alti | more | |
| Funeral Director | - | 214-20-2628 | 6. Sex 7. A | 7 4 | last birthday) Yrs. | If Undar 1 Ye Months Da | ear If Undar 24 Hrs ays Hours Min | 8. Dala of B (Month, L Jan. | irth Pay, Year) 12 1925 | 9. Birthpla Count Mary | ace (Stete or Foreign (y) Iand | |
| /land | | Usual Rasidanca of Decedani 10a. Slate 10b. County | | 10c. C | ity, Town or Loc | cation | | | | 10 | d. Inside City Limits | |
| Mar | tor | MD. Baltin | nore | Lu | thervil | le | | | | | 1 ☐ Yas 2 ☐ No | |
| or 28 | Director | 10e. Street end Number | | | | 10f. Zip Cod | ia | | 10g. Citizan of | Whel Count | ry? | |
| 23a | 2 | 505 Spring Ave | э. | | | 21093 | 3 | | | USA | | |
| bs 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at | by Funeral | 11. Maritel Status 1 Nevar Married 2 Merrie 3 Widowed 4 12 Divorced | 12. Was Decadan Armed Forcas od 1 1 Yes 2 If Yas, Give Yaar or Datas | ?] No W | | | of Hispanic Origin? (S Cuban, Maxican, Puar No Specify: | Specify Yas or N no Rican, aic.) | o- 14. Ra Bie Specia | ce - America ock, Whita, a by: Whi | itc. | |
| tural straight | | 15. Decedant's | | | 16a. Deced | ant's Usual Oc | cupation | | 16b. Kind of E | | | |
| nin 7 | plet | (Specify only highast Elamentery/Secondary (0-12) | grada complatad) | · F · \ | (Giva k | kind of work do O NOT use re | ccupation one during most of wo tired) | orking | TOD. INITIO OF E | 0311103311101 | zatiy | |
| od win | Completed | 7 | Coilaga (1-4or | 3+/ | Mechan | ic | | | Auto I | ealer | | |
| all Hy | Be | 17. Fathar's Name (First, Middla, Li | ast) | | | | 18. Mothar's Na | ma (First, Middl | ma) | | | |
| Meni | 2 | Charles Ward | Ethel | Hedric | k | | - | | | | | |
| 12 sh h and h sur r is m | | 19a. Informant's Name/Ralationshi | | . 20 | | | reetend Numberor R Ct. Cocke | | | | Code) | |
| Health Fire 27 | | Mrs. Susie Jacks 20a. Mathod of Disposition | son/ Daugnice | | Place of Dispos | | | Data | 20c. Location | | om Piale | |
| nent of I | | DD Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe | | | cematary, cram rkwood | atory or other | plece) | 4-21-99 | | | | |
| Defilimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Martel Hygines. Important: if item 27 is marked other than "neture!", or any injury or other traumatic event, the Healtest Exen- | | 21. Signature of Funeral Service Li | Service Licensee 22. Name and Addrass of Facility | | | | | | | | | |
| OF S | | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 | | | | | | | | | | |
| 10 | | 23a. Part1. Enter the disease, or o shock, or heart failure. List of | omplications that cause | d iha daa | th. Do not enle | r tha moda of | J YOPK Rd. dying, such as cardia | Towson c or raspiratory | , MD. 21 arresi, | | Approximate | |
| Physician | | | my one seems on beam | mines. | | | | | | | Approximate Interval Between Onset end Death | |
| /Medical Examiner | | Immediata Cause (Final disease or condition rasulting in deeth) | CHRONI | CO | STRUC | TIVE L | _UNG DIS | EASE | | | | |
| -xammer | 7 | rasulting in deeth) | i | | | | | | | | | |
| nsit | nine | | b | | | | | | | | | |
| physician and s the bunal-transit | Aedicai Examiner | Sequantially list conditions, if any, leeding to immadiate | | Due to (| or as a consequ | ience of): | | | | i | | |
| ysicia e bur | Cai | Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or Injury that indieted avants resulting in deality Last Due to (or as a consequence of): | | | | | | | | | | |
| C) 65 | Med | resulting in daaln) Last | | | | 01,00 | | | | | | |
| ttendi or us | Physician/ | | d | | | | | | | 1 | | |
| the a | ysic | Part II. Other significant conditions | contributing to deeth | but not ras | sulting in the un | deifying causa | givan in Part i. | 23b. Die | tobacco use co | ontribute to | the cause of death? | |
| vaician: . The law requires that the death cert is certificate has been signed by the attendin director, page 2 should be detached for use | y Ph | | | | | | | 1)1 | Yss 2□ No | 3 Probe | ably 4 Unknown | |
| n sign | ed by | | | | | | | 24e. Wa | s an autopsy | 24b. War | ra autopsy findings | |
| s bee | Completed | | | | | | | per | ormed? | com | ilabla prior to pletion of cause eath? | |
| ite ha | mo: | | | | | | | 1□ | Yas 20 No | 10 | Yes 2 No | |
| rtifica ctor, p | Bec | 25. Was case refarred to medical examinar? | | | | | 26. Placa of De | ath (Check only | | | | |
| rthis certific | To | 1 ☐ Yas 2 🕱 No | Hospital: | iant 2 | ER/Oulpatient | 3□ DOA | Other: 4 Nursing I | Homa 5 ☐ Ras | sidence 8 DOt | nar (Specify) |) | |
| ther th | :uo | 27. Mannar of Deeth 1 Natural 5 □ Panding | 28a. Data of Inj (Month, D | ury a <i>y Year)</i> | 28b. Tima of Injury | | njury et Work? | 28d. Describe | how injury occu | rred | | |
| tor: A | cati | 2 Accident invastiga 3 Suicida 8 Could no | tion t be | | | | 1 ☐ Yas 2 ☐ No | 006.1 | | | | |
| Direc | Certification: | 4 ☐ Homicida datarmin | ed 28e. Place of Ir building, a | | | at, factory, offi | Ce | | (Street end Num. own, Stata) | ber or Rurai | Houle Number, | |
| within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical C | (Uneak only 2 Medical Ex | Physician: To the best caminar: On the besis of | of axamina | wiedge, deeth | occurred at the | a tima, data and place | e, and due to the urred at tha tima | causa(s) and m | annar as sta | ited. | |
| To the Hospital or Attending Phys within 24 hours affer death. To the Funeral Director: After this completely filled in by the funeral director. | Med | one) | end manner s | tated. | | | | | | | | |
| ¥ 1 8 | | 29c. Licensa number 29d. Date signed (Month, Day, Y | | | | | | | | | | |
| , 1/ | | 20 Name and address of services | no completed | don't fir | - 220) (T | | laus teef "T | | 4 - | 10" | | |
| /X/ | | 30. Name and address of person with BOON P. LIM, | | | , | | TOWSON. | MARYI A | ND 2120 | 214 | | |
| Sta | te | 31. Date filed (Month, Dey, Yeer) | 32. Regist | | | | | - H - H \ 1 3 - E | v v dear — Sees alle Sees S | - | | |
| Registr | | APR 2 1 1 | 1999 | مصوري | 19. | Ana | Val. | | | | | |

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Werner 4:00 pm 04 /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner Larkin Chase Nursing Home Prince Bowie leorge's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) July 2,1912 Birmplece (State or Foreign Country)
 PA Funeral XX M 2 F Months Deys 86 Yrs. 179-09-2858 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Locetion r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Prince Georges Director 1 ☐ Yes 2 No Bowie Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13122 Forest Drive 20715 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 157 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Hem 27 1s marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: White by 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Mens Suit Mfg. 12 Foreman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Nem 27 1s marked oth any Injury or other treammit even once. Be Warren Werner Rhine 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13122 Forest Drive, Bowie Maryland Luanne Brown / Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 XX emovel from State Richland Cemetery April 20,1999 Richland, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Neme end Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, Maryland 21230 23a. Pert1. Enter the disease, or complications that caused had death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical das Examiner Physician/Medical Examiner The law requires that the death certificete be executed use es the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury P.O. Box 68760. thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown Cerebral vascal acc. It signed b Records, þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Conjective Heat fulin 1□ Yes No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes cese referred to medical 28. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes → No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide Hospital 18 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

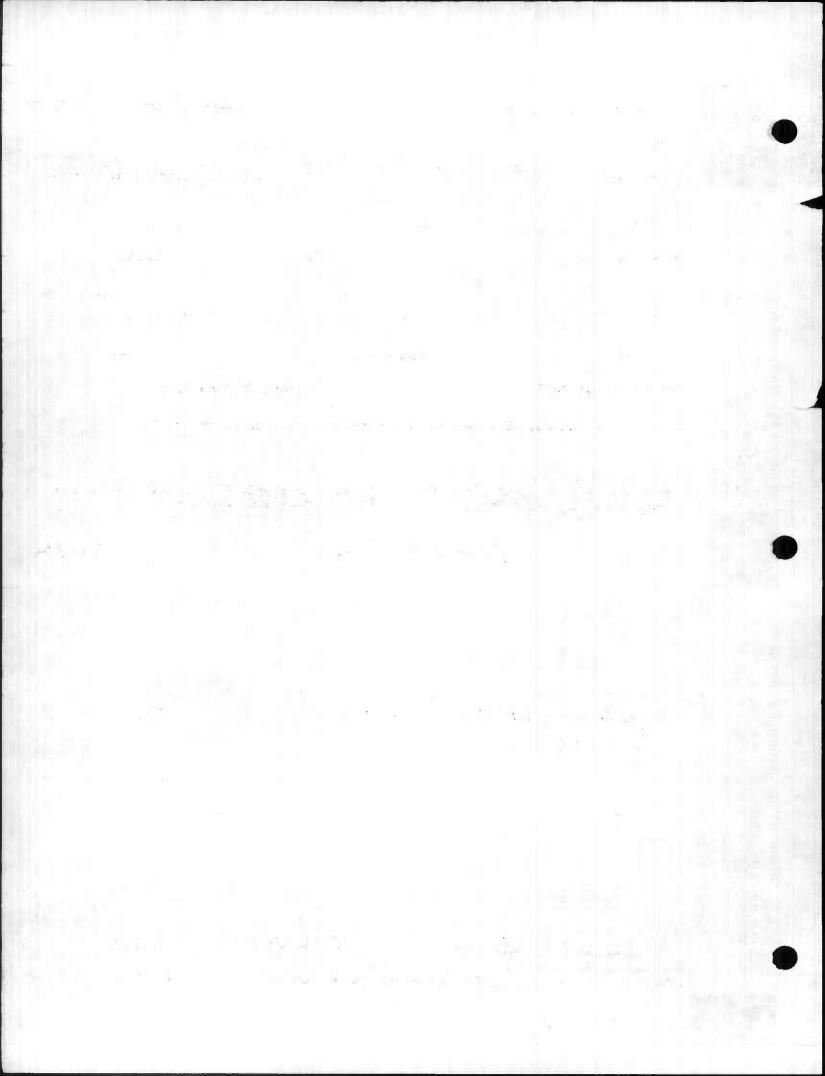
2 Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical completely (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0051113 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Schwortz 14300 Gallent fo h. Lune mn 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State APR 2 1 1999 Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | Cei | tificate | of | Death | | | Reg. No. | | |
|--|----------------|---|---------|------------------------------|-------------------------|-------------------------|------------|----------------------------|----------------|-------------------|-----------------|-----------------------------------|---------------------------|-------------------------|---|
| | | 1. Decedent's Name (First, Middl | e, Last |) | | | | | | | | 2. Dete of De Month | eeth Dey | Yeer | 3. Time of Deeth |
| Physician /Medica | _ | Carolyn Bel | 1 W: | ilson | | | | | | | | April | * | 999 | 5:45 PM |
| Examine | | s Fecility Neme (If not institution | n, give | street end nu | n <i>ber</i>) | | | | 1 | b. City, To | own, or Lo | ocation of Deet | h 4c. | County of Dee | th |
| 43 | в | 3904 Greenway | у | | | | | | | Bal | timo | re | | | |
| Funeral | | 5. Social Security Number | 6. Se | | 7. Age (| In yrs. lest i | birthday) | If Under 1 Months | Year | If Under Hours | 24 Hrs. Min. | 8. Dete of Bi (Month, De | rth ev. Year) | 9. Bir | thplace (Stete or Foreign |
| Director | | 003-14-5740 | 11 |]м 2ЙО г | | 76 | Yrs. | | | | | April | 22,19 | 923 Mas | sachusetts |
| P | - | Usuel Residence of Decedent 10e. Stete 10b. County | | | 1 | Oc. City, To | wn or Lo | cation | | | | | | | 10d. Inside City Limits |
| Aarylen f show | 5 | Manual and | | | | D. 14. | | | | | | | | | 1 X Yes 2 □ No |
| the Maryles | Director | Maryland | | | | Balt | LMOT | 10f. Zip C | ode | | | | 10o. Citiz | zen of What Co | puntry? |
| th with | <u></u> | 3904 Greenway | | | | | | | 212 | 18 | | | | J.S.A. | , |
| death with the Maryland ms 23a or 28a-f show crives be notified at | Funeral | 11. Maritel Stetus | | 12. Wes Dece | edent Eve | er In U,S. | 13. \ | | | | rigin? (Sp | ecify Yes or No Rican, etc.) | | 14. Race - Ame | |
| _ 5 2 E | | 1 ☐ Never Married 2 🕅 Men | ried | Armed Fo 1 ☐ Yes | 2 X No | | | | | | | Rican, etc.) | | Bleck, Whit | |
| E . 5 0 | þ | 3 Widowed 4 Divorced | | If Yes, Giv Yeer or D | etes: | | | I□Yes 2 | Ų No | Specify | : | | | Specify: W | hite |
| 5-00. | Completed | 15. Deceden (Specify only highe | t's Edu | cetion | | 16 | e. Deced | lent's Usuel | Occup | ation | st of work | ina | 16b. Kir | nd of Business | Industry |
| within see. | d | Elementery/Secondary (0-12) | or grau | College (1 | 1-4or 5+) | | life. I | kind of work DO NOT use | retired | 1) | or work | 9 | | | |
| d 212 filed within Hygiene. ther then ent, the M | 5 | 12 | | 5 | | I | lome | naker | | | | | | Own Hom | е |
| Maryland 2 d 2 should be filed the and Mental Hygis 7 is marked other traumatic event, II | Be | 17. Fether's Neme (First, Middle, | | | | | | | | | | e (First, Middle | | | |
| arylan should be nd Mental merked o | 2 | George Ernest | | | | | | | | | | Voodman | | | |
| ire, Maryland is and 2 should be filed the and Mental Hygitem 27 is marked other traumatic event. | | 19e. informant's Name/Reletions | | | | | | | | | | el Route Numb | | r Town, Stete, | Zip Code) |
| e, and teelth mazz | | Theodore H. Wi | lso | n, Jr., | | | | Green sition (Neme | | , Ba | ltimo | ore, MD | | 218 cation - City or | Tour State |
| or of P | 1 | 20a. Method of Disposition 1 □ Burial 2 □ Cremetion | 3 □F | Removel from | | ceme | tery, crer | netory or oth | er ple | ce) | 1 | Date | 20G. LO | cation - City of | TOWN, Stele |
| Baltimore, M pemil. Peges I and 2 Department of Health of Important: If Nem 27 is any Injury or other tre page. | | 4 Donetion 5 □ Other (S | | | | | | | | | - | | | | |
| Department on the control of the con | | 21. Signeture of uneral Service Ronald | | | Dire | ector | | Name end | | | | 1. 655 | W. Ra | altimor | e Street |
| 40264 | 1 | Suman, | 10 | Mes | 4_ | | Ba | altimo | re, | Mary | yland | 1 2120 | 1 | | |
| | | 23a. Part1. Enter the disease, or wock, or heert feilure. List | only or | icetions thet one ceuse on e | eused the | ne deeth. D | o not ent | er the mode | of dyir | ng, such es | s cardiac | or respiretory | errest, | | Approximete Intervel Between |
| Physician | | | | 0 | | | 0 | (| | | | | | | Onset end Death |
| /Medical Examiner | - 1 | immediate Ceuse (Finel disease or condition resulting in deeth) | | e. | un | eren | لاد | Con | 0 | \ | | | | | Monto |
| 200 | | | | | Du | ue to (or es | e consec | juence of): | | | | | | | |
| nsit nsit | Examiner | | | b | | | | | | | | | | | |
| axecu and al-tre | Exa | Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury | | | Du | ue to (or es | e consec | uence of): | | | | | | | 1 |
| OX 68 / 60, certificate be associted ding physicien and ise as the burial-trensit | Ca | thet initieted events | | C | Du | e to (or es | e consen | neuce off. | | | | | | | |
| Ufficat ug phy es th | 8 | resulting in death) Lest | | | Du | 10 (0) 03 | o corrabq | denos ory. | | - 0 | | | | | |
| 0 - 5 - 1 | N N | | | d | | | | | | | | | | | |
| het the death of by the etten deteched for u | Physician | Pert II. Other elgnificant condition | one cor | ntributing to de | eath but r | not resuiting | in the u | nderlying cau | ise giv | en in Pert | i. | 23b. Dld | tobacco | uaa contribut | to the cause of death |
| od by the deteche | يا ک | Il. Jan | | 14/0 | Street | 7 | 41 | OAI | 0 4 | .1 | | 1 | Yee 2 | ©No 3□F | robably 4 Unknow |
| | by | Hypotensa | | 1110 | good | , | 611 | 0 117 | /01 | | | | | | |
| HECOLOS, ne lew requires t s hes been signe ge 2 should be | 2 | Solulla | to | | | | | | | | | | en eutop | 24b. | Were eutopsy findings eveileble prior to |
| Hecc e lew re hes be ge 2 sh | ple | James | | | | | | | | | | | | | completion of ceuse of death? |
| | Completed | | | | | | | | | | | 10 | Yes 20 | DNO | 1 ☐ Yes 2 ☐ No |
| Or VICAL The Physician: The this certificate ral director, peg | | 25. Was cese referred to medice exeminer? | 1 | | | | | | | 26. Pled | e of Deel | th (Check only | опе) | | |
| Of VItal Physician: this certific ral director, | 0 | 1 Yes 2 10 | ŀ | Hospitel: | Inpatient | 2 🗆 ER/ | Outpetier | it 3□ DOA | Ott | er: 4 🗆 N | ursing Ho | ome 5 1 Res | idence 6 | 6 □Other (Spe | ecify) |
| JING Ph Jing Ph After thi funeral | | 27. Manner of Deeth 1 ☐ Naturel 5 ☐ Pendir | 10 | 28e. Dete (Mon | of Injury th, Dey Y | (ear) 28t | Time of | 280 | . Injur Wor | y at k? | | 28d. Describe | how injur | y occurred | |
| Or Attending strands of the Control | catle | 2 ☐ Accident Investi | gation | | | | | М | | Yes 2□ |]No | | | | |
| r Attend fractor: n by the | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | nined | 28e. Plece buildi | of Injury ng, etc. (| - At home, (Specify) | farm, str | eet, fectory, | office | | | | (Street en own, State, | | lural Route Number, |
| J est le | | | | | | | | | | | | | | | |
| Division To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the | edicai | (Check only 2 Medical | | ner: On the bi | asis of ex | xaminetion | | | | | | end due to the red et the time | | | s stated. e to the cause(s) |
| thin 2 the mple | | one) 29b. Signeture end title of certifie | ır | and men | ner stete | 0. | | 290 | Licens | e number | | | 29d Dat | e signed (Mon | th. Dev. Year) |
| 7× 7 8 | | Durel C | 4 | 121. | a form | h | | 200. | | 263 | 91 | | | 113/99 | |
| | - | pe 10-22/07 | , , | A | | | | | ., | | , | | 7 | 112111 | |
| | | 30. Name and address of person | | empleted caus | | th (Item 23e | (Type, | Print) | -0 | Spn | ING | LA | R | MIN | MDZILIK |
| CATA | | 31. Dete filed (Month, Dey, Year) | | 32 D | egistraris | s Signature | 1 | 1 | 1/20 | Val. | | | , | | |
| State Registra | ٠ | APR 2 | 0 19 | 399 | C. San Jel | 5 | 1 | · Jose | 1-61 | | | | | | |
| 3 | | LAL IV IS | | | | | | | | | | | | | |

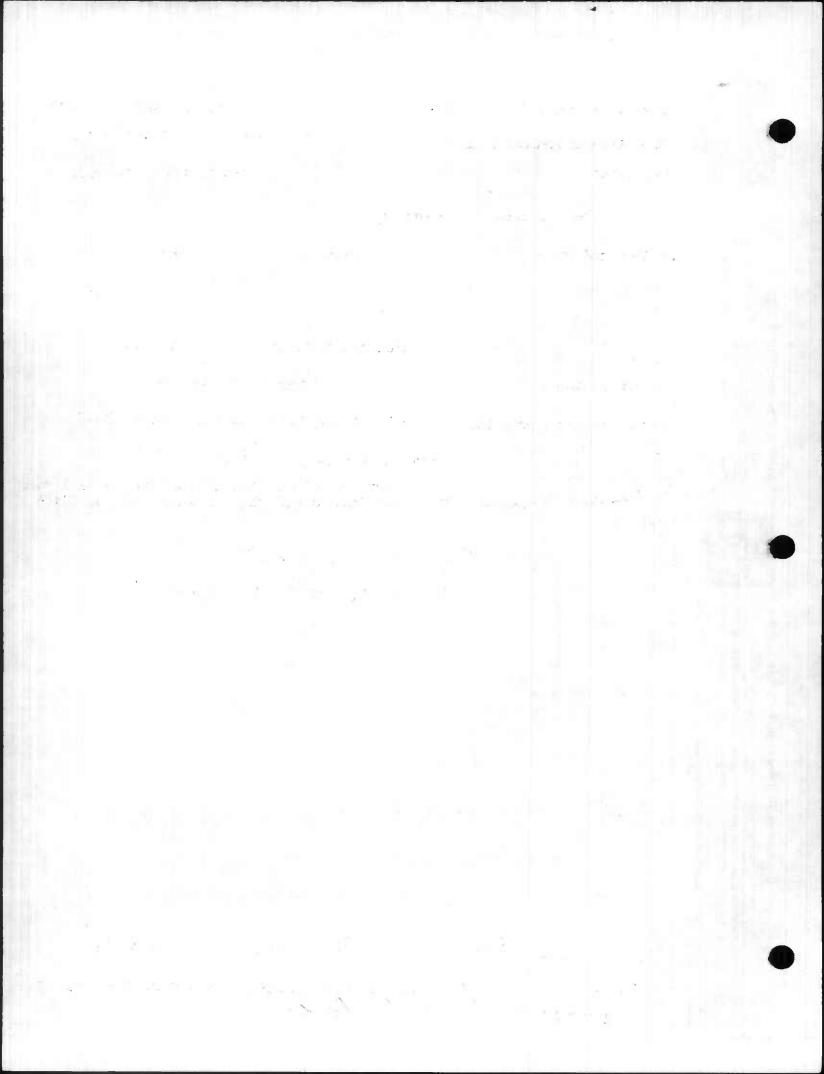
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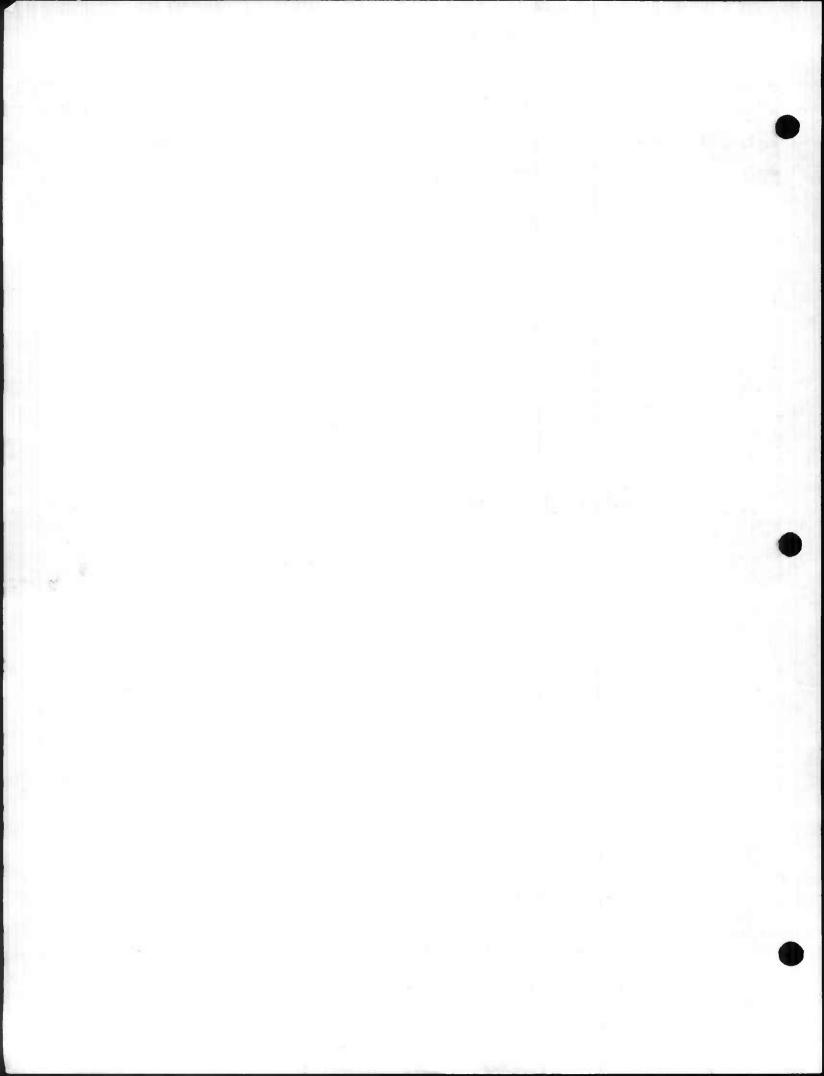
| | | | | | aryland | | ertificate of | | | Reg. No. | | 3074 |
|--|----------------|--|-----------------------------------|---|--|------------------|--|--|---------------------------------------|---------------------------------|------------------------------------|--|
| Phys | ician | Decedent's Neme | | | 201 | | | | 2. Date of De Month | Day | Year | 3. Time of Death |
| | dical | Theodo | | | Adams | | | | I L | 7, 1999 | 100 | 1605 |
| Exan | niner | 4a Facility Name (If | | | | | | 4b. City, Town, or L Annapoli | | | Arun | idel |
| *V | | Anne Ar 5. Social Security Nu | | dical Cen | ter ge (in yrs. last | hirth do | v) If Under 1 Yeer | If Under 24 Hrs. | | | | |
| Funer Directo | | 022-01-53 Usual Residence of I | 41 1 | M 2□ F | 93 | Yrs. | Months Days | Hours Min. | 8. Dete of Bi (Month, Di NOV 2, | 1905 | Color | lace (State or Foreign try) Cado |
| and wa | | | 10b. County | | 10c. City, T | own or | Location | | | | 1 | 0d. Inside City Limits |
| Many 4 sh | tor | MD | Anne A | rundel | Sever | na I | Park | | | | | 1 ☐ Yes 23 No |
| the Tage | Director | 10e. Street end Num | ber | | | | 10f. Zip Code | | | 10g. Citizen of V | What Coun | try? |
| 3a o | | 407 Fernw | ood Driv | re | | | 21146 | | | USA | | |
| Maryland 21215-0020 d 2 should be filled within 72 hours after death with the Maryland th end Mental Hygiene. 7 is marked other then "netural", or items 23s or 25s-f show treumstic event, the Medical Examinating required. | by Funeral | 11. Marital Status 1 □ Never Marrie 3 □ Widowed 4 | | 12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates: | ? No | 13 | B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No | | pecify Yes or No Rican, etc.) | o- 14. Rac Blac Specify | e - Americ ck, White, w: Whi | etc. |
| 15-002 in 72 hours | De De | 10-1 | 15. Decedent's Ed | lucation | 1 | 6a. Dec | cedent's Usual Occup | ation | le lan an | 16b. Kind of Bi | usiness/Inc | dustry |
| within 7 then 'n the wed | Completed | Elementery/Secon | y only highest gra dary (0-12) | College (1-4or | 5+) | | ve kind of work done DO NOT use retire | | Killy | Dointi | na | |
| d 212 filed within Hygiene. other than | Con | 12 | | | | Pa | ainting Co | | | Painti | | |
| be filed htal Hygi of other | Be | 17. Father's Name (F | | | | | | | | e, Maiden Surner | 10) | |
| arylan should be nd Mental marked o | 2 | Hampton | L. Adams | | | | | Carrie | | arned | | |
| Maryla 42 should h end Mer 7 is marke | | 19e. Informent's Nar | | | | | iling Address (Street | | | | | |
| | | | | daughter | | | 7 Fernwood | | | | | |
| 0 00 0 | | | | Removal from State | cem | etery, c | position (Name of rematory or other plan ill Cemete | | pr 10 1999 | Quinc | | |
| Baltim permit. Pag Department Important: I | DOCE | 21. Signature of Fun | etal Servine Liceo | 5 | | _ 1 | 22. Name and Addre Barranco & 495 Gov. F | Sons, P | | | | neral Home |
| S8760, licate be executed by sician and by sician and sthe buriel-transit | Examiner | Immediate Cause (F disease or condition resulting in death) Sequentially list con- if any, leading to immediate. | ditions, nediate | a | Due to (or es | no | equence of): | vrest | dis | sease | | Onset and Death |
| BOX 68760, death certificete be executed by the extending physician of or use as the bune | an/Medical | Ceuse (Diseese or in that initiated events resulting in death) La | ijury | d | Due to (or es | a cons | equence of): | | | | | |
| hat the cd by the detached | by Physician/M | Part II. Other signific | ant conditions of | ontributing to death I | but not resultin | g in the | underlying cause given | ven in Pert I. | | tobacco uae co Yes 2☑No | | o the cause of death? bably 4 Unknown |
| aw requisite to the second sec | Completed b | | | | | | | | 24e. Wa | s an autopsy formed? | av | era autopsy findings allable prior to impletion of cause death? |
| The L | E O | | | | | | | | 1 🗆 | Yes 2 No | 1[| ☐Yes 2☐ No |
| r Vital I yalcian: Th is certificate director, pag | Be | 25. Wes case referre | ed to medical | | | | | 26. Plece of Dea | ith (Check only | one) | 1 | |
| Of Vita Physician: this certific ral director, | To | 1 Yes 2 2 N | lo | Hospitel: 1 Inpat | ient 2 ER | /Outpat | | 4 Unursing H | | sidence 6 Ott | | y) |
| nding Phath. r: After the funeral | | 27. Manner of Death 1 Natural 2 Accident | 5 Pending investigation | 28a. Dete of Inj (Month, De | ury ay Year) 28 | b. Time Injun | / Wo | ryat rk? Yes 2 □ No | 28d. Describe | how injury occur | red | |
| DIVISION if or Attending stater death. i Director: After id in by the fune | Certification: | 3 ☐ Suicide 4 ☐ Homlcide | 6 Could not be determined | 289. Place of Ir | njury - At home ntc. <i>(Specify)</i> | , farm, | street, factory, offica | | 28f. Location City or To | (Street and Numi own, State) | ber or Rura | il Route Number, |
| DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funersi Director: After th completely filled in by the funeral | edicai C | | | | of examination | | eth occurred at the ti investigation, in my o | | | | | |
| To the To the | Me | 296. Signature and ti | tle of certifier | 0 | | | 29c. Licens | se number | | 29d. Date signe | d (Month, | Dey, Year) |
| | | | Jh | ~ 02 | m | | 0.7 | 20 14 | | 4-8 | 5 - 4 | , , |
| | State | Jeffrey 31. Date filed (Month | Schmidle | in, M.D. | | DV. | Ritchie H | | e 206, | Severna | Park | , MD 21146 |
| Regi | | | APR 091 | | epera | 1 | . , spar | the state of the s | | F | | |

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State of Maryland / Department of Health and Mental Hygiene 9 9 1 3 0 7 5

| | | | | | | Cer | tificate of | Death | | 4 | Reg. No. | | 0010 |
|------------|--|------------------|--|--|----------------------|------------------------|--------------------------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------|-------------------------|---|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Las | ANDE | ERS | ON | | | | 2. Date of De Month 34 - | Day - | Yeer 79 | 3. Time of Death 7.38 pm |
| | Exami | | 4e. Facility Neme (If not institution, give | street end number) | | | | 4b. City, Too Syk.E | wn, or Local | ation of Death | 4c. County | | _ |
| | Funeral Director | | 5. Social Security Number 6. Security Number 10 Security Number 10 Security Number 11 Sec | ox ☐ M 2☐XF | e (In yrs. last bi | rthdey) Yrs. | If Under 1 Yeer Months Days | If Under: | Min. | Date of Bird (Month, Da Jan. 9 | h y, Year) , 1934 | | elece (Stete or Foreign stry) yland |
| | s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mentel Hygiene. I Health and Mentel Hygiene. I he marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinat must be notified at | Funeral Director | 10e. State 10b. County Maryland Baltin | more | 10c. City, Tow | | ation more | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | or 20 | Dire | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of \ | Vhat Cour | ntry? |
| | 23a | rai | 3429 Abbie Plac | | | | | 21244 | | | United | Stat | es |
| | ter dee | une | 11. Maritel Status | 12. Wes Decedent E Armed Forces? | | 13. W | as Decedent of F Yes, specify Cub | fispanic Orig en, Mexican | gin? (Speci , Puerto Ri | fy Yes or No can, etc.) | 14. Rac Biad | e - Americ k, White, | an Indian, etc. |
| 20 | rs eff | by F | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates: | lo | 1 | ☐ Yes 2 No | Specify: | | | Specify | | |
| 21215-0020 | n 72 hours natural', | | 15. Decedent's Edu | | 168 | Decede | ent's Usual Occup | ation | | | 16b. Kind of Bu | | ite |
| 215 | nin 72 | Completed | (Specify only highest grad | fe completed) | | (Give k | ind of work done O NOT use retire | during most | of working | 7 | Own Ho | | dostry |
| 213 | filed within Hygiene. other then ent, the We | E O | Elementary/Secondery (0-12) 12th | College (1-4or 5 | +) | Hous | ewife/se | creta | ry | | Private | | any |
| pu | e file othe vent, | Bec | 17. Father's Name (First, Middle, Last) | | | | | | | First, Middle, | Maiden Suman | ie) | |
| Maryland | should be filed within and Mentel Hygiene. marked other than umatic event, the Mentel and the Me | To | Vernon Schisler | | | | | Kat | e Low | e | | | |
| lan | 2 sho end I s me | | 19a. Informant's Name/Reletionship (T | ype, Print) | 198 | . Mailing | Address (Street | and Numbe | er or Rural I | Route Numbe | er, City or Town, | State, Zip | Code) |
| | 1 end Heelth em 27 | | Lois Smith/ Daught | ter | | | Greenwa | y Driv | ve E | llicoț | t City, | MD | 21042 |
| ore | Pages 1 nent of H nt: If iter nry or oth | | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F | Removal from State | 20b. Place of cemete | of Dispos bry, crem | ition (Name of atory or other pla | ce) | | Dete | 20c. Location - | City or To | own, Stete |
| Ë | men ment: luny | | 4 ☐ Donation 5 ☐ Other (Specify) | | Lake | View | Mem. Pa | ark | 4/ | 7/99 | Sykes | ville | , MD |
| Baltimore, | permit. Peges 1 end 2 s Department of Heelth ar Important: If Item 27 Is any Injury or other trau once. | | 21. Signature of Funeral Service Licens | 100 | | | Name and Addre | | | -1 D' | - | T) A | |
| | 00 F e d | | amore | 1 Cover | W | 1 | urrier-Q 212 W. O | ld Lil | perty | al Dir Road | ectors, Winfie | P.A. | D 21784 |
| | | | 23s. Part Lenter the disease, or comp | ications that caused ne ceuse on each in | the deeth. Do | not ente | r the mode of dyle | ng, such es | cardiac or | respiratory e | rest, | | Approximate tnterval Between |
| А | Physician | | | 01 | | | | | 1 | | | i | Onset end Deeth |
| 1 | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. 1713 | heim | er | 3 1)4 | mer | ntia | | | i | |
| ı | | _ | resoluring in death) | ا | Due to (or es a | consequ | ence of): | | | | | I | |
| 7 | ped nsit | Examiner | | b | | | | | | | | | |
| _ 01 | and and el-train | хаг | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury | | Due to (or es e | consequ | ence of): | | | | | i | |
| 260 | siciar b buni | | Cause. Enter Underlying Ceuse (Disease or injury that Initiated events | c | | | | | | | | | |
| 68760, | certificate be executed iding physician and ise es the buriel-transit | /Medicai | resulting in deeth) Last | L | Due to (or as e | consequ | ence or): | | | | | 1 | |
| X | andin use | 2 | | d | | | | | | | | | |
| œ. | that the deeth of ad by the etten detached for u | Physician | Part II. Other significant conditions co | ntributing to death bu | t not resulting i | n the un | deriving cause giv | ven in Part I | _ | 23b. Did 1 | obacco use co | atribute to | the cause of death? |
| P.0 | t the d by the tached | , Ty | • | | | | | | | | Yes 2 No | | bably 4 Unknown |
| | es that | by F | | | | | | | | | | | |
| Records, | aw requii is been s 2 should | Completed | | | | | | | | | an autopsy med? | av | ere autopsy findings ailable prior to mpletion of cause death? |
| æ | The law ate has page 2 | E | | | | | | | | 123 | res 2□No | 1[| Yes 2 No |
| Vital | | Be | 25. Wes case referred to medical exeminer? | | | | | 26. Plece | of Deeth (| Check only o | ne) | | |
| of V | 5 w 5 | 2 | 1 Yes 2. No | Hospital: 1 🗆 Inpatier | nt 2 ER/O | utpatient | 3□ DOA Oth | ner: 42 Nu | rsing Home | 5 Resid | lence 6 Oth | er (Specif | y) |
| n c | | :: | 27. Menner of Deeth 1. Natural 5 ☐ Pending | 28e. Date of Injury (Month, Day) | | Time of | 28c. Inju | ry et rk? | 28 | d. Describe I | now Injury оссил | ed | |
| sio | Attending or death. rector: After by the fune | cati | 2 ☐ Accident investigation | | | | | Yes 2 1 | No | | | | |
| Division | | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Inju building, etc. | | arm, stre | et, factory, office | | 28 | f. Location (S City or Tox | Street and Numb m, Stete) | er or Rure | I Route Number, |
| | urs e urs e ral D | | | | | | | | | | | | |
| | To the Hospital or within 24 hours efte To the Funeral Dir completely filled in | ledicai | 29a. Certifier 1 Coertifying Phy (Check only one) | sicten: To the best of ner; On the basis of and manner ste | examination ar | e, death ad/or inve | estigation, in my o | pinion, deat | d place, and th occurred | at the time, | dete and placa, | and due to | the ceuse(s) |
| | To To | Σ | 29b. Signature and title of certifier | 40.11 | | 7 | 29c. Licens | e number | 7// 0 | | 29d. Date signe | (Month | Dey, Year) |
| | | | of mestine | way ht | , IVI | V | D = | 2 | 140 | | 04 | 05 | 74 217011 |
| | | | 30. Name end address of person who co | ompleted cause of de | path (Item 23a) | Type, P | rint) 710 | Obre | cht | Road | d, Syke | SVI | le MD 84 |
| | Sta | te | 31. Date filed (Month, Day, Year) | | | 1. | 1 | 4 | • | | · | | , |
| | Registr | | APR 0 7 199 | 39 Sen | wa | Ø. | Spark | 2 | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 9.30 **Physician** March 30, 1999 MELVIN LEVY ANGEVINE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Prince Georges 6801 Bock Road Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-13-14 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months 1□M 2対F 84 Yrs. 229-36-3549 Essex Co. VA Director Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours eftar death with the Marylen and Mental Hygiens.
7 Is marked other than "netural", or items 23a or 28e-f show traumatic event, the Medical Exeminar master notified as 1√2 Yes 2 No Director Maryland Prince Georges Fort Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zlp Code 6801 Bock Road 20744 USA Funeral 14. Race - American Indian. 12. Was Decadent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 1 ☐ Yes 2 ☑ No Specify: 3altimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: Specify: American Indian g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4 or 5+) Catholic Church 8 Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pearl Bundy James Bundy 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health end Important: If Item 27 Is in eny Injury or other traun page. 6801 Bock Road, Fort Washington, Maryland 20744 of Disposition (Name of Dete 200. Location - City or Town, State Alonzo Angevine 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Buriel 2 Cremetion 3 Removal from State Arlington National Cem. 4-8-99 Arlington, VA 4 □ Donetion 5 □ Other (Specify) 21. Signatury of Funeral Service-Deeps 22. Name and Address of Facility Strickland Funeral Services, PA 6500 Allentown Road, Camp Springs, MD 20748 23a. Pel-1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Cordigovlmonery disease or condition resulting in death) Examiner Examiner 4 mai physician and s the buriel-trensit certificate be asscuted Due to (or es a consequenca of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760 Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of) 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. signed by t 1 | Yes 2 | No 3 Probably 4 ☐ Unknown py 24b. Were eutopsy findings aveileble prior to 24a. Wes en eutopsy Completed peen completion of cause of death? 1 Yes 2 No 2X No 1 TYes certificata Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5X Residenca 6 Other (Specify) 2 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this uneral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation or Attendiates of Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mospital 24 hours a Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

| Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the 29e. Certifier To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) iper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of the 29c. License number 29d. Dete signed (Month, Day, Year)

(4)

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

APR 0 6 1999

32. Registrer's Signature

of person who completed ceuse of death (Item 23e) (Type, Print)

(Type, Print) 6900 George 10 Ave NW MO CPT, MC Washington DC 20037-5108

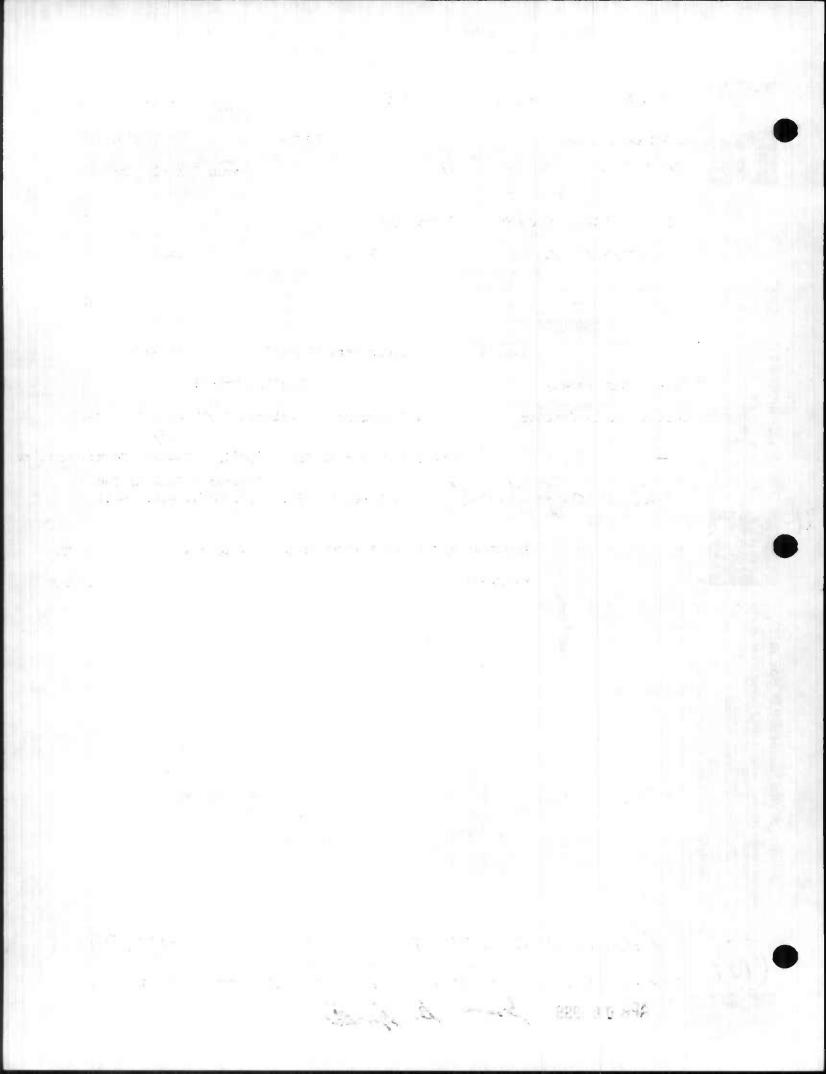
And the same and given and noting the gi

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| | | | | | | | Cei | uncai | e ui | Dealli | | | Reg. No | 0. | | |
|----------------------------|---|--|-----------------------|-------------------|------------------------|---|--|------------------|----------|---------------------------------------|------------|------------------------------------|--------------|------------------|------------------------|---|
| sician edical | 1. Decedent's Na RONDA | | | HELLE | | | ASHI | EY | | | | 2. Date of D Month APRIL | 4, 1 | 999 | Year | 3. Time of Death 6:00am |
| miner | 4a Facility Name MANOR CA | RE LARG | 0 | | | | | If Under | | LARGO |) | ocation of Dea | P | | E GE | CORGES |
| ral tor | 5. Social Security | 7932 | 6. Sex | м ЖЕ | 7. Aga | (In yrs. las | st birthday) Yrs. | Months | | | Min. | 8. Date of B (Month, I March | 7,19 | 62 | 9. Birth Cou BER | place (State or Foreign intry) MUDA |
| | Usual Residance | 10b. Count | v | | | 10c. City. | Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| tor | MD | | | ORGES | | | ESTVII | | | | | | | | | XXYas 2□No |
| rec | 10e. Street and h | | ,E OE | оподы | | 1 0101 | 201 V 11 | 10f. Zip | Code | | | | 10g. C | itizen of \ | What Cou | intry? |
| a D | 2815 CR | ESTWICK | PLA | CE | | | | 207 | 47 | | | | U.S | S.A. | | |
| by Funeral Director | | sarried 2 Ma | rried | If Yes, G | orces? 2⊡ No ive | | | | | Hispanic Or pan, Mexica Specify | | pecify Yas or No Rican, etc.) | No- | | ck, White. | |
| q pa | 3 La Midowed | 15. Decede | | Yaar or E | Jatas: | | 16a Deced | lent's Usua | al Occu | nation | | | 16h. l | Kind of B | | .ack |
| Completed | | ecify only high condery (0-12) | est grade | completed) | (1-4or 5+) | | (Give | kind of wo | ork done | pation during mos ed) | st of worl | king | | | | , |
| Com | Liementery/Se | condeny (0-12) | | 2yea | | ' | Resp | oirat | ory | Thera | apis | t | Pr | ivat | e | |
| To Be | 17. Father's Nam James Pe | | | | | | | | | | | e Pring | | n Sumen | 10) | |
| | 19a. fnformant's Lucille | | | | | 2 | | | | | | rel Route Num 11 Sout | | | | |
| | | Disposition 2 Cramation 5 Other (| | amoval from | State | | ce of Disponetery, crem | | | | 4/ | Date 10/99 | | | | own, State |
| Physician/Medical Examiner | 23e. Pert1. Ente shock, or h Immediate Caus disease or cond resulting in deet Sequentially list if any, leeding to cause. Enter Ur Cause (Disease that Initiated eve resulting in deat | e (Final tition h) conditions, immediate derlying of injury nts | 8. b. c. d. | ACQU | IRED MONIA | IMMU Due to (or e A Due to (or e a Due to (or a | Do not enter JNE DE se e consequence as a consequence a | EFICI uence of): | ENC | ing, such as | s cardiac | SYNDRO | arrest, DME | co use co | ntributa | Approximate Inferval Between Onset and Death YEARS MONTHS |
| d by Pt | | - | | | | | | | | | | | Yes | | | Vere autopsy findings |
| Completed by | | | | | | | | | | | _ | pe | rformed? | , | 8 | vallable prior to completion of cause of death? |
| Con | | | | | | | | | | | | 10 | Yes : | 2XXV0 | 1 | ☐ Yes 2☐ No |
| 8 | 25. Was case re examiner? | terred to medica | - | ospital: | | | | | | | e of Dee | th (Check only | y one) | | | |
| - To | 1 Yes 2 | | | 10 | Inpatient | | R/Outpatien 8b. Time of | | UA | 711 | ursing H | ome 5 Re 28d. Describ | | | | ity) |
| Certification: | 1 ⊠Naturel 2 ☐ Accidan 3 ☐ Suicida 4 ☐ Homicid | 5 Pendi invest | tigation | 28a. Dete (Mor | e of Injury | | Injury a, farm, str | М | | Yes 2 |] No | 28f. Location | | a <i>nd</i> Num! | | ral Routa Number, |
| edical Cer | 29a. Certifier (Check only | 1 Certifyi | ing Physi I Examin | ician: To the | e best of e | my knowle | edge, death | occurred | at the t | ime, date a | nd place | , and dua to th | e cause(| (s) and ma | anner as and due | stated. to the cause(s) |
| Medical Certificati | 29b. Signature a | | | and mer | ner stete | ed. | MO | 29 | c. Lican | sa number | | | | | | n, Day, Year) |
| State | 30. Name and ac RAKESH 31. Date tiled (M | ARORA, | M.D. | 14300 | 00 GA | | T FOX | | E SI | JITE_2 | .22_H | BOWIE, | MARY | LAND | 207 | 15 |
| jistrar | API | 0 6 19 | 99 | Ses | year | - 1 | 9. | Loca | أفيع | | | | | | | |

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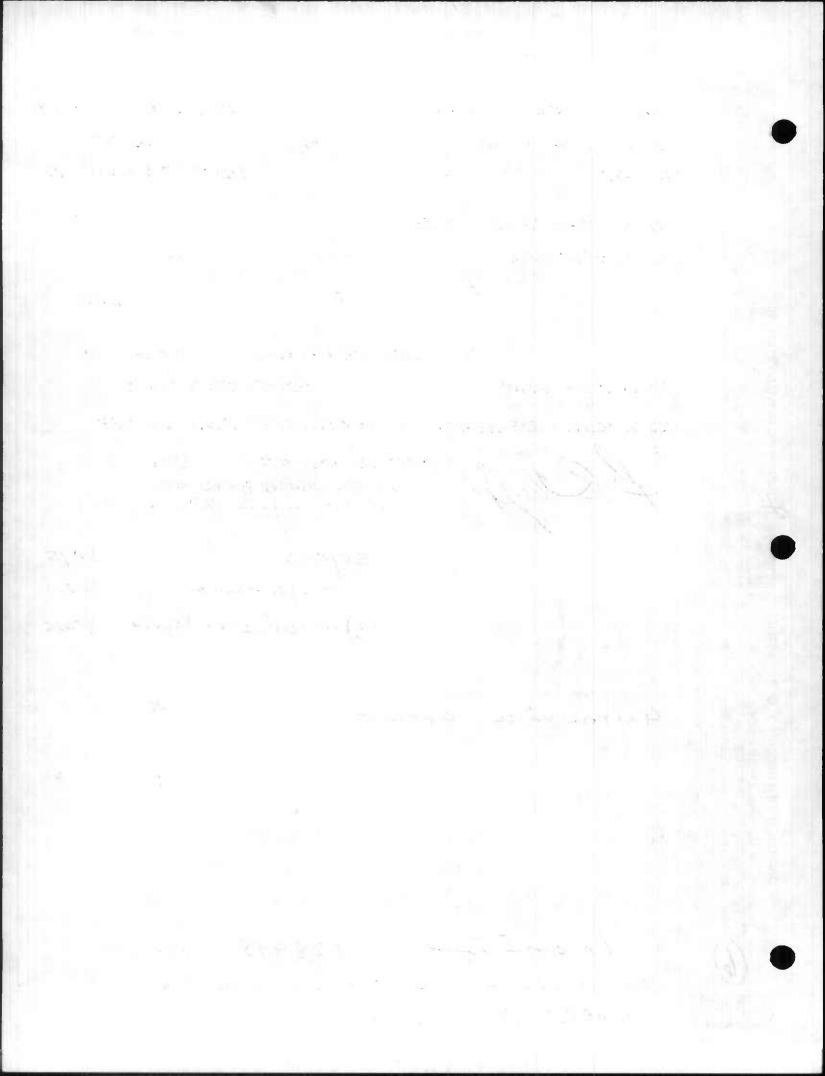


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** APRIL 4, 1999 AUSTIN MARY 4:20 PM JANE /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE GOLDEN OAKS NURSING HOME LAUREL If Undar 1 Year If Undar 24 Hrs. Min. Months Days Hours Min. July 27, 1 9. Birthplace (Stata or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. 1908 RIDGLEY, MD 90 Director 577-46-5260 Usual Rasidanca of Decedant the Manylend 10d. Insida City Limits 10a State 10h County 10c. City. Town or Location "natural", or items 23s or 28s-f show adical Examiner must be northed at 1 Yas 2 No Directo MARYLAND PRINCE GEORGE BELTSVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with in and of Health and Martell Hygiens.

NI: If item 27 is marked other than "natural", or items 23a or 3 ury or other traumatic event, its items and other traumatic event. 11901 ELLINGTON DRIVE 20705 U. S. A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 【No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: BLACK by 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry 15. Dacadant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) Etemantary/Secondary (0-12) Collaga (1-4or 5+) COSMETOLOGY & PHOTOGRAPHY SELF EMPLOYED 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be GERTRUDE COMFORT DUBOIS JOSEPH CHARLES BANTON 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 114 - 54TH ST., S. E. WASH., D. C. 20019 MARY J. AUSTIN - SELF-PRE-NEED 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 M Burial 2 Cremation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. 4 Donation 5 Other (Specify)
21. Signature of Funeral Service Liceo MARYLAND NAT. MEMO. PARK 4/7/99 LAUREL, MD PINCKNEY-SPANGLER FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only include a cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition resulting in daath) /Medical Examiner Examiner physician and the burial-transit that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the Gastric ula, Anemia 1 Yee 2 No 3 Probably 4 Unknown P 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of causa of daath? cartificate hes lirector, paga 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 No To the Hospital or Attanding Physician:
within 24 hours after death.

To the Funeral Director: After this cartification and plately filled in by the funeral director, it 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1XX latural 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 | Homicide edicai 1 X Certifying Phyeician: To the best of my knowladga, daath occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, date and place, and dua to the cause(s) and mannar stated. 29a. Certifier 29b. Signatura and titla of certifiar 29c. License number 29d. Data signad (Month, Dav. Year) rilam 5 81 APRIL 5, 1999 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) 9101 CHERRY LANE SUITE 211 LAUREL, MD 20708 PRITAM SAINI, M. D. 32. Registrar's Signatura 31. Data filad (Month, Day, Year) State APR 0 6 1999 Registrar



B.K.S State of Maryland / Department of Health and Mental Hygiene VIOLET VIRGINIA ARNOLD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, 1999 ARNOLD **Physician** VIRGINIA MOLET APRIL 8:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 20 F Months Hours 78 215-18-8754 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MEYERSDAUE SOMERSAT 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? filed within 72 hours efter deeth with I Hygiene. Wher than "naturel", or Rema 23a or I r than "naturel", or flams 23s or 15552 218 SAMSON USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Privo
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER Pages 1 and 2 should be filed nent of Heelth end Mentel Hygi mt: If Nem 27 le marked other Baitlmore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 89 BAKER 6. EDWARD 19a. Informant's Name/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 SAMSON ROCK RD. MEYERSUAUE, OWEN F. ARNOLD of Heelth . Nem 27 Is r other tre HUSBAND 20a. Method of Disposition
1 Derial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete permit. Pages Department of Important: If it eny injury or o 4-8-99 MEYERSIMLE, GREENVILLE UNION CETTE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility WILLIAM ROLLE PRICE FUNERAL HOME, FD-011249-L 325 MAIN ST. MEYERSDAUE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Cause (Finel Pulmonary hrom 60 - 6m 60lism disease or condition resulting in death) Examiner Physician/Medical Examiner enous been signed by the ettending physicien and should be deteched for use as the buriel-transit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Cardinascular Disease Records, Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 EYes 2 No certificate WZ Yes 2□ No Division of Vital funeral director, 25. Wes case referred to medical examiner?

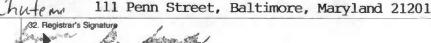
12 Yes 2 No 26. Place of Deeth (Check only one) Hospital: XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation t Matural To the Hospital or Attending within 24 hours effect death. To the Funeral Director; Affe completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Comparison: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

5 nus

ennisu 31. Date filed (Month, Day, Year) State APR 0 7 1999 Registrar

30. Name and address of person why



eted cause of death (Item 23a) (Type, Print)

STATE OF

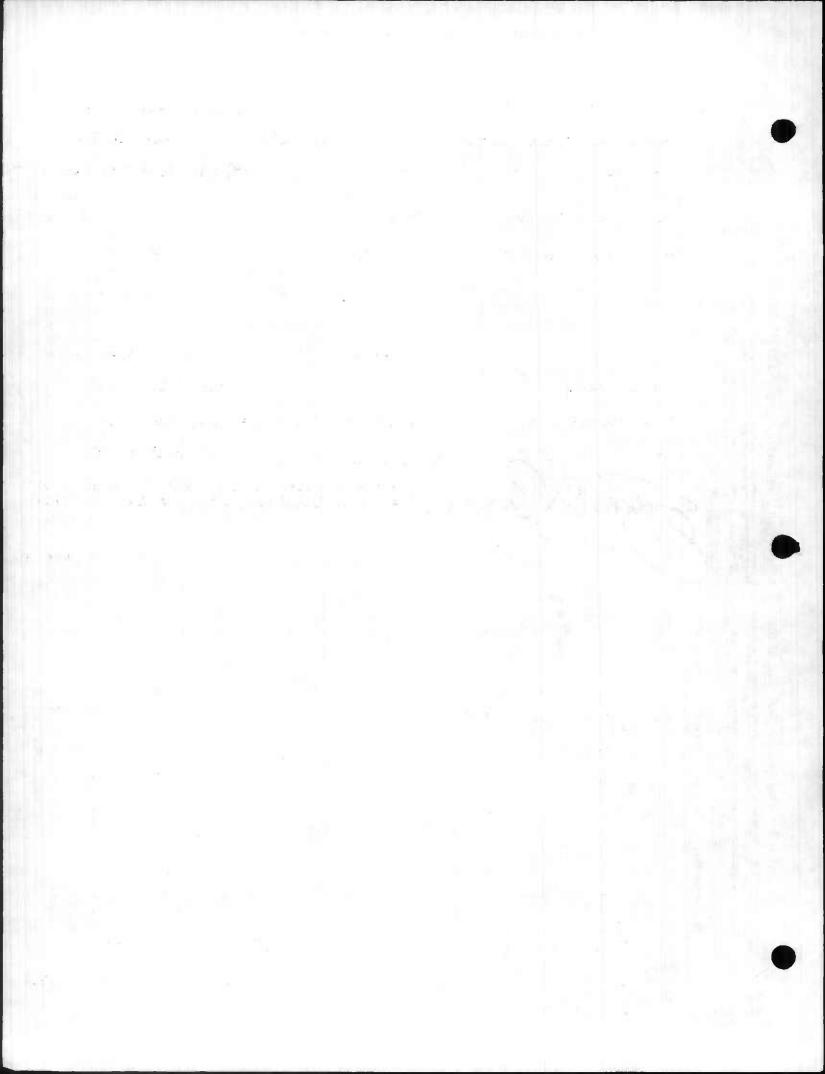
O.C.M.E

APRIL 5, 1999

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month **Physician** Julia Eva Barnhart 7, 1999 1820 April /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept 16, 1 9. Birthplece (State or Foreign Country) New York 5. Soclei Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 200 F Months Days Hours 114-12-9960 80 Yrs. 1918 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyderes. Incorporate if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, for Medical Examinal Inval by notified at once. 10d. Insida City Limits 10a Stete 10b. County 10c. City, Town or Location MD Anne Arundel Annapolis 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 847 Chestnut Tree Drive Funeral 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detas: 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fathar's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumeme) Katherine Obschenski Casper Laska 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Gene Barnhart / son 847 Chestnut Tree Drive, Annapolis, MD 21401 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Apr Date 10 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State Castleton, NY 4 ☐ Donation 5 ☐ Other (Specify) Horizon View Cemetery 1999 22. Name and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home MD 21146 495 Gov. Ritchie Hwy., Severna Park, Approximete Intervel Between Onset and Deeth Do not enter tha mode of dying, such es cardiac or raspiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical UN KNOWN neumonia Due to (or es a consequence of): Exam and -Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest Due to (or es a consequenca of): physician a s the burlat-Box 68760 certificate be Physician/Medical Due to (or as a consaquanca of) 10 gribnette 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown heart failure tha signed t by The law requires 24b. Were eutopsy findings available prior to completion of cause of death? been sig 24a. Was an autopsy performed? Completed cartificate has b 2. No 1 Yes 1 ☐ Yes 2 ☐ No dementia director, or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Copatient 2 | ER/Outpetient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this funeral 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tes 2 No investigation after death Director: A d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours aft Funeral Di letaly filled in Hospital Cartifying Phyalcien: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29e. Certifier edicai completaly (Check only one) within 2 29c. License number 29d. Data signed (Month, Dev. Year) 29b. Signeture and title ol certifier 2 0053277 MD who completed cause of deeth (item 23e) (Type, Print) 30. Neme and eddress of person Annapolis MD 21403 31. Date filed (Month, Day, Year) APR 0 9 1999 32 Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth

| Physician | |
|-----------|--|
| /Medical | |
| Examiner | |

WILLIAM A. BOOTH

4a Facility Name (If not institution, give street end number)

APRIL 1999 4 4b. City, Town, or Location of Deeth 4c. County of Death

3. Time of Death 1600

10d. Inside City Limits

Approximete Interval Between Onset end Death

4 weeks

29d. Date signed (Month, Dey, Year)

13 UD 21401 Messics, M.D.

1 Yes 2 No

Funeral Director

the Maryland traumatic event, the Medical Examiner must be notified at 6 Items 23a permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Health end Mental Hyglena. Important: if fem 27 is marked other the any injury or other traumers.

Physician /Medical Examiner

physician and the bunal-trans use as been signed by the should be detached page 2

requires that the death certificate be executed or Attending Physician: After this after death Director: To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the

Division of Vital Records, P.O. Box 68760

ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 1 M 2□ F Yrs. 212-34-9851 NOV. 6 1937 MARYLAND Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location MARYLAND ANNE ARUNDEL ANNAPOLIS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 US 1315 MCKINLEY STREET Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify: p 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US NAVAL ACADEMY 12th 0 PAINTER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be DAISY BLUNT ERNEST BOOTH 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARY TAYLOR (FRIEND) 1315 MCKINLEY ST. ANNAPOLIS, MD. 21403 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERAN CEME. 4/9/99 CROWNSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest lan/Medicai Due to (or es e consequance of):

| Part II. Other eignificent conditions of | - Jensian | | | 23b. Did tobacco uaa co | ontribute to the cause of deat |
|--|--|--------------------------|---------------------------------|--|---|
| Diabe | to Med | lle Fis | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
| 25. Wes cese referred to medical | | | 26. Place of D | Death (Check only one) | |
| examiner? | Hospital: | SER/Outpatient 3 | DOA Other: 4 Nursing | Home 5 ☐ Residence 6 ☐Ott | her (Specify) |
| 27. Manner of Death Neturel 5 Pending Accident Investigation | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury et Work? 1 Yes 2 No | 28d. Describe how injury occu | rred |
| 27. Manner of Death Neturel 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be determined | | nome, farm, street, fact | ory, office | 28f. Location (Street end Num City or Town, State) | ber or Rural Route Number, |
| 29a. Certifler | | | | ice, and due to the ceuse(s) end m ccurred et the time, date and plece, | |
| 29b. Signature and title of certifier | | | 29c. License number | 29d. Date signe | ed (Month, Dev. Year) |

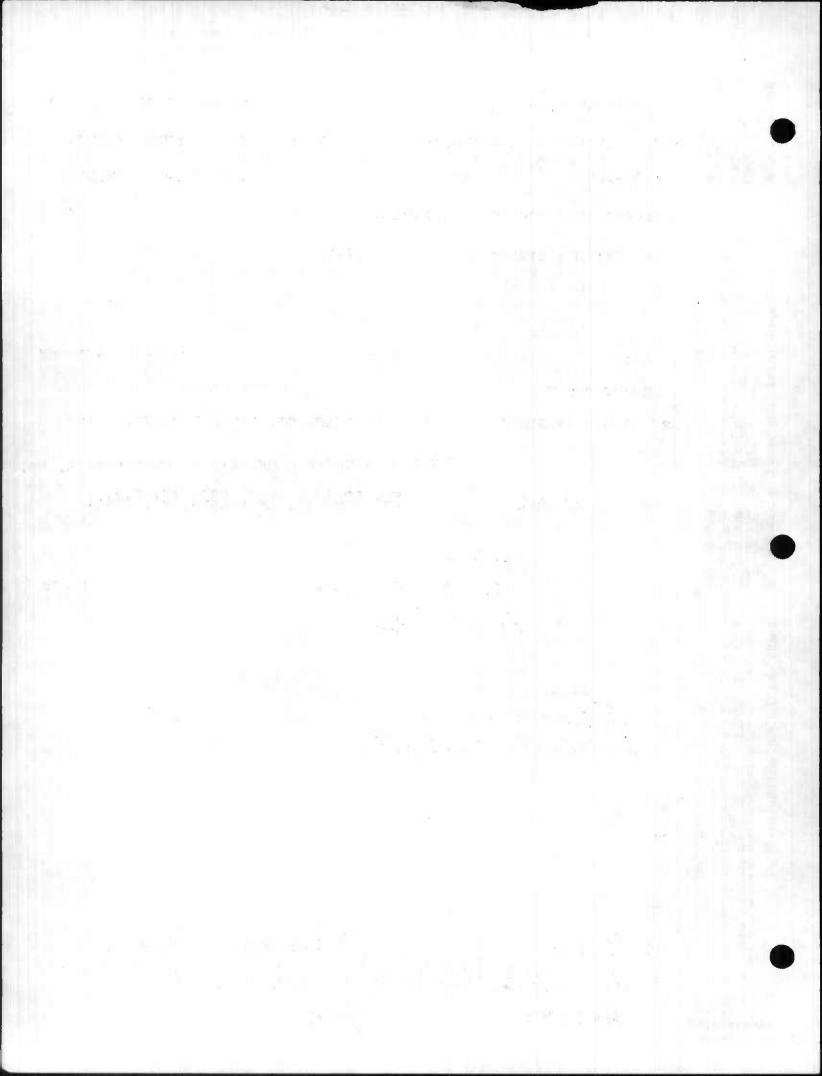
State Registrar 31. Date filed (Month, Dey, Year) APR 0 8 1999

29b. Signeture and title of certifier

ochrane 32. Registrar's Signature

pleted cause of deeth (Item 23a) (Type, Print)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth Month **Physician** RERAMS SR KENNEIH 8:20 Am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner MARYLAND MOSTCAL SYSTEM BALTEMORE BALTEMORE CITY UNDUERSDITY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 6. Sax **Funeral** 1⊠M 2□F Months Deys 216-42-8969 Yrs. MAryland 55 Director Sept 3, 1943 Usual Rasidance of Decedant with the Maryland r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 TYas 2 No 4) estminster MAryland Director Arroll 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Item 27 is marked other than "natural", or Items 23a or other treumstic event, the Medical Examiner must be re Ridge 21157)SA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a any Injury or other treumatic event, the Wed 245 Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14 Baca - American Indian 11. Marital Stetus Black, Whita, atc. 1 Nyes 2 No 1966 -If Yes, Giva Year or Dates: 1968 1 Naver Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Whit Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Engineer Systems 12 18. Mothar's Name (First, Middla, Maiden Sumama) 17. Fathar's Nema (First, Middla, Last) Albert 3. Berends IATA MAUNES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Ridge 150 Westminster mo 21157 Joan K. Berends (wife) 2453 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 1 Buriel 2 Cremation 3 Removel from State Meadow Branch Cemetern 4 ☐ Donation 5 ☐ Other (Specify) 4/10/99 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee Pritts Funeral Home + Chapeli 412 Washington Rd Westminster 21157 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Intervel Batween Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical MULTI-SYSTEM CORLAN FATHERE I WEEK **Examiner** Due to (or es e consequence ot): Examiner SEPSIS 2 WEEK physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disease or injury that initiated evants resulting in death) Lest Dua to (or as a consequence of): EMD STAGE LIVER 1 MONTH Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): as esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s or Attending Physician: funeral director. 25. Was cesa referred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 2☐ ER/Outpatient 3☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending 24 hours after death. Funeral Director: Af 1 □ Yas 2 □ No invastigation 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and pennsy flated. 29a, Certifie Medical (Check only one) within 2 To the

29c. Licansa number

MANYCANO

MOSTLAL

30. Name and address of person who completed cause of death (Itam 23e) (Type, Print) 22 S. GREENE ST., BALTIMORE, MD

UNTUBBLER

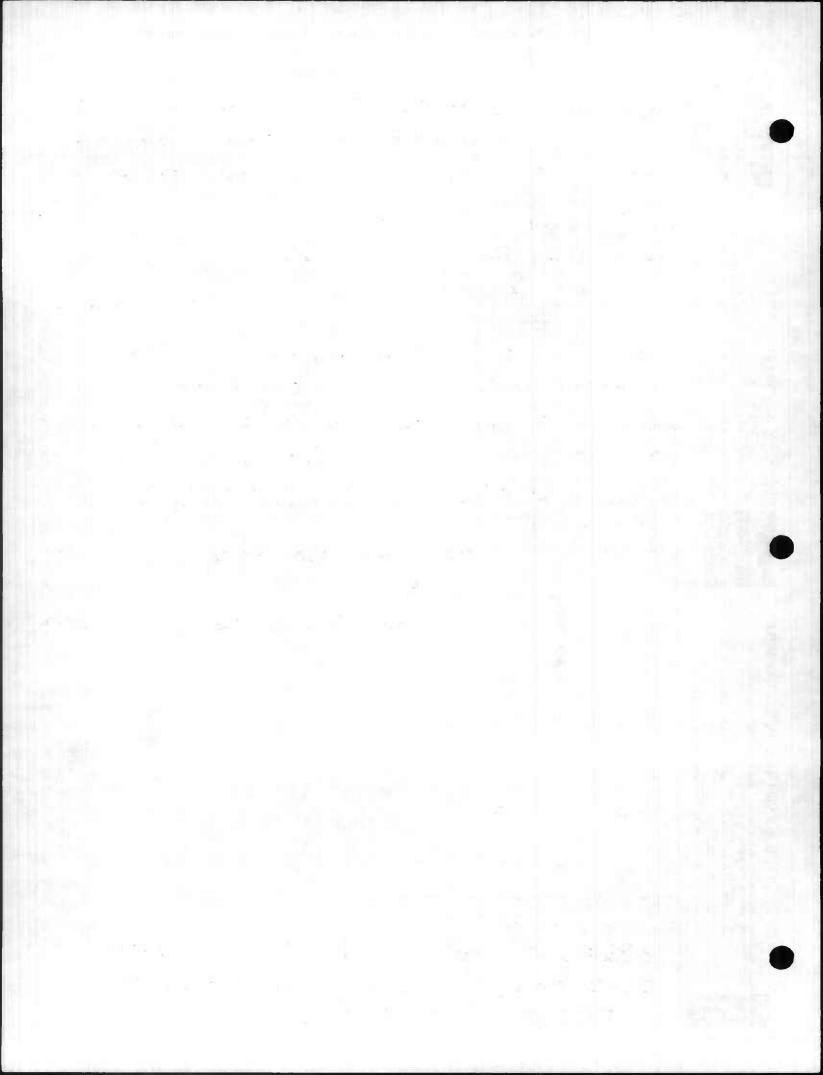
MD U 32. Ragistrar's Signatura

29d. Date signed/(Month, Day, Year) 99

State Registrar 29b. Signature and little of pertitie

31. Data filed (Month, Dey, Year)

APR 0 5 1999



State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Nama (F | irst, Middle, Las | st) | | | | | 2. Data of De | | | 3. Time of Death |
|----------------|--|-------------------------------|---|--------------------|-------------------------|---|---|--------------------------------------|-------------------|--|---------------------------------------|
| ician | CLEVELA | NID | L. | BUSI | 4 | | | April | 4, Day 199 | Yaar 9 | 8:15 PM |
| al er | 4a Facility Name (If not | | | | | | 4b. City, Town, or | | | | |
| ₽r | Montgomer | | | _ | | | Olney | | Montgo | | |
| | 5. Social Security Number | | | | last birthday) | If Under 1 Year | | s. 8. Date of Bi | | | e (Stete or Foreign |
| | 264-58-295 Usual Residence of Dec | 3 1 | ™ 2□ F | 59 | Yrs. | Months Days | Hours Min | 8. Date of Bi (Month, Do Sept. | 14,1939 | Jackso | e (State or Foreign) nville, F |
| | | b. County | | 10c. Ci | ty, Town or Loc | cation | | | | | . Inside City Limits |
| 010 | MD M | ontgome | ry | Si | lver Sp | ring | | | | | 1 Ves 2 No |
| Director | 10e. Street and Number | r | | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Country | ? |
| | 14104 Wood | well Te | rrace | | | | 20906 | | U.S. | Α. | |
| by runeral | 11. Marital Status 1 □ Never Marriad 3 □ Widowad 4 □ | | 12. Was Decede Armed Forca 1 Yes 2 (If Yas, Give Yaar or Date | s? XNo | | Vas Decedent of Yes, specify Cul | Hispanic Origin? (ban, Mexican, Pue Specify: | Specify Yas or Norto Ricen, etc.) | Blac | e - American k, White, etc Black | |
| Completed | | Decedent's Econly highest gra | | | (Give I | ent's Usual Occu kind of work done OO NOT use retin | during most of we | orking | 16b. Kind of Bu | usiness/Indus | itry |
| E | Elementery/Seconde | ry (0-12) | College (1-4d | | | | | | U.S. Ca | nital | |
| | 17. Father's Neme (Firs | st Middle Leet | 1 + yea | IS | Compu | ter Spe | | me (First Middle | Maiden Surnam | A | |
| o Be | Cleveland | | | | | | | Jackson | ., ournall | -/ | |
| 2 | 19a. Informant's Name | | | | 10h #4all- | o Address /Ctra | et end Number or F | | oer City or Tour | State Zin Co | ode) |
| | Ruby K. Bu | | | | | - | 1 Terr., | | | | |
| | 20a. Mathod of Disposit | | | 20h | | sition (Neme of | , | Date | 20c. Location - | | |
| | 1 ☑ Burial 2 ☐ C | | Removal from Sta | te | cem <i>etery</i> , crem | etory or other pl | | | | | |
| | 4 Donation 5 | Other (Specify | y) | Fo | rt Linc | oln Cem | etery | 4-10-99 | Brentwo | od, MD |) |
| | 21. Signature of Funera | al Service Licen | isee | | 22. | Name and Add Marshal | ress of Facility I's Fune | ral Home | , Inc. | | |
| | Dy F | m | a. La | 10 | | | h Street | | | DC 20 | 0011 |
| | 23a. Parts. Enter the d | lisease, or com | plications that cause one cause on each | ind the deal | th. Do not ente | | | | | A | pproximate iterval Between |
| | SINON, OF HOUSE IN | noro. Clar only | 0110 00030 011 000 | | | | | | | | Insat and Death |
| | Immediate Causa (Fina | al | GEDGEG | | | | | | | 10 | Dave |
| | disease or condition resulting in death) | | a. SEPSIS | | or es e consequ | uence of)- | | | | 110 |) Days |
| Jer | | | DEMENT | | oo a conseq | 231100 017. | | | | 1.0 |) Years |
| Examiner | Sequentially list one did | ione | b. DEMENT | | or as a consequ | uence of): | | | | 110 | , icars |
| EX | Sequentially list conditi if any, leeding to imma- ceuse. Enter Underlyin Ceuse (Diseese or Injur | diate | | 220 10 (1 | | | | | | | |
| Cai | that initiated events | | C | Dua to // | or as a consequ | uanca of): | | | | | |
| edicai | rasulting In death) Last | | | 200 to (C | as a consequ | currous Off. | | | | | |
| | | | d | | | | | | | | |
| Cla | Death Other 1 M | | | | Maria II. | | 1 1 D 1 | 1 001 01 | l Anhana c | | |
| Physician/M | Part II. Other eignifican | nt conditions o | ontributing to death | n Dut not ras | sufting in the un | nderlying ceuse g | iven in Part I. | | | | he cause of death? |
| 7 | | | | | | | | 1 | Yee 2X No | 3 Probab | bly 4 ☐ Unknown |
| d by | | | | | | | | 24a Wa | s an autopsy | 24b. Were | autopsy findings |
| Completed | | | | | | | | per | ormed? | availe | able prior to pietion of cause |
| idu | | | | | | | | | | of dea | ath? |
| 3 | | | | | | | | 1 🗆 | Yes 2 No | 1 🗆 Y | res 2□ No |
| De | 25. Was cese referred axaminer? | to medicel | | | | | 26. Place of De | eath (Check only | one) | | |
| 0 | 1 Yes 2 No | | Hospital: | atient 2 | ER/Outpatien | 1 3□ DOA O | ther: 4 Nursing | Home 5 ☐ Res | idence 6 Oth | er (Specify) | |
| | 27. Manner of Death | Pendina | 28a. Date of II | njury Dey Year) | 28b. Tima of Injury | 28c. Inj W | ury at ork? | 28d. Describe | how Injury occur | red | |
| atic | 2 Accident | Pending investigation | 1 | , , | ,, | | ☐ Yes 2 ☐ No | | | | |
| Certification: | 3 ☐ Suicide 6 | Could not be determined | 28e. Plece of | Injury - At h | ome, farm, stre | et, factory, office | 9 | 28f. Location | (Street end Numb | per or Rurel R | louta Number, |
| e l | - C Hollidge | | bullaing, | etc. (Speci | 7/ | | | Only of 10 | , water | | |
| edicai | | | niner: On the besis | of examina | | | time, date and place oplnion, deeth occ | | | | |
| Med | 29b. Signatura and title | of cartifier | and manner | olaide. | | 29c Licer | nse number | | 29d. Date signe | d (Month. Da | ay, Year) |
| - | Lob. Orginatura and title | 7 | | II | | | | | | 8, 199 | |
| | P.G. / | hake | cr. | MU | | D43 | 1430 | | April | 0, 19 |) J |
| | 30. Name and address | of person who | completed ceuse o | death (Iter | m 23a) (Type, I | Print) | | | | | |
| | | | | | | | | | | | |
| | Gaurang Th | | M. D. 181 | 11 Pr | ince P | hilip Dr | ., Olney | , MD 208 | 332 | | |

1963 C 1968 C 1971

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** CAROLYN BASS 2346 APRIL 04, /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** GEORGES PRINCE FORT WASHINGTON HOSPITAL FORT WASHINGTON If Under 1 Year If Under 24 Hrs. Birthptace (Stata or Foraign Country) 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days Months 10 M 20 F 578-52-7898 Director 05-05-41 Wash., DC Usual Rasidanca of Dacedant 10a. State 10c. City. Town or Location 10d. Insida City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at XX Yes 2 No Washington Directo None 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 5904 Blaine St., Funeral 20019 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status Black, White, atc. 1 Yas 2 No If Yas, Give Yaar or Datas: 72 hours after 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2□ No Specify Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) the Medical 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Hygiens. Elamantary/Secondary (0-12) Coltega (1-4or 5+) Housewife Own Home 12th marked other 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be nent of Hesith and Mental Lafayette Vance Ruth Spriggs 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other trau . Tambra Johnson, Daughter 12501 Gable Ln., Ft. Washington, Md. 20744 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removel from State 4-9-99 Donation 5 Othar (Specify) Forest Hill Cemetery Clinton, Md. re of Funeral Service License 22. Nama and Addrass of Facility Ralph Williams Funeral Service 517 11th St., SE, Washington, DC 20003 23a. Part1. Entar tha disaesa, or complications that caused tha daath. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or haar failura. List only ona causa on each line. Approximata Intarvat Batween Onsat and Deeth **Physician** /Medical Immediata Causa (Final HYPERTENSIVE ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquanca of) Examiner physician and the bunal-transit that the death certificate be executed Sequentially list conditions, if any, taading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting In death) Last Dua to (or as a consaquanca of): P.O. Box 68760 Physician/Medical Dua to (or as e consequenca of): attanding signed by the a Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown ASTHMA Records, þ law requires 24b. Wara autopsy findings eveileble prior to Completed 24a. Was an autopsy performed? peeu PIABETES MELLITUS complation of causa of daath? certificate has t The 1 Yas 2 No 1 Yas 2 No Division of Vital director, Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Chack only ona) examinar? Hospitat: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28a. Data of Injury (Month, Day Yaar) 27. Manpar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 1 Natural 5 Panding death. 1 ☐ Yas 2 ☐ No invastigation 2 Accidant by the 6 Could not be datarmined 3 Sulcide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Direc 4 D Homicida hin 24 hours after the Funeral Dire npletaly filled in b 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical Within 2
To the F 29d. Data signad (Month, Day, Yaar) 29b. Signato 29c. Licansa number DME

State Registrar

MARTO F. MD GOL 31. Data filed (Month, Day, Year) APR 0 9 1999

372

32 Ragistrar's Signatura

3001

d cause of death (Itam 23a) (Type, Print)

APRIL 05, 1999

DRIVE CHEVERLY, MARYLAND 20785

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Physicia | an | 1. Decedent's Name (First, Middle | | C K | | | | 2. Date of Dea | Reg. No. | Year | 3. Time of Deat |
|---|------------------------------|---|--|---|--|--|---|---|--|------------------------------|---|
| /Medic | ai | V - | 1 K.15U | | | | | 3 | 25 | Year 99 | 7 An |
| Examin | er | 4a. Facility Name (If not institution | | | | | 4b. City, Town, or Lo | | To Cooking | | |
| | | Mariner Hea 5. Sociel Security Number | | ington Age (In yrs. lest bin | hday) If Under | | Kensington If Under 24 Hrs. | | Montg | | (Chat F |
| unerai irector | | 216-44-4215 Usual Residence of Decedent | | | Yrs. Months | Days | Hours Min. | 8. Date of Birth (Month, De) May 3, | 1908 | Counti | nce (State or Ford y) ana |
| how | | 10a. State 10b. County | | 10c. City, Town | or Location | | | | | 10 | d. Inside City Lim |
| 23a or 28a-f show | Director | Maryland Montg | omery | Kensi | ngton | | | | | | 1 □ Yes 2 🖺 |
| or 2 | Dire | 10e. Street end Number | | | 10f. Zip | Code | | | 10g. Citizen of \ | | - |
| 238 | ra . | 3000 McComas | | | | 2098 | | | United S | | |
| | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorcad | 12. Wes Deceder Armed Force ed 1 Yes 2 If Yes, Give Year or Date: | s? ₹No | 13. Was Deced | | ispanic Origin? (Spi en, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | Specify | ce - America ck, White, e | |
| o cal | Completed | 15. Decedent (Specify only highes Elementery/Secondary (0-12) 1 2 | 's Education t grade completed) College (1-4o | | life. DO NOT us | rk done d se retired | during most of work | ing | 16b. Kind of Bi | | |
| ont, | Be Co | 17. Father's Name (First, Middle, I | Last) | | Secret | ary | 18. Mother's Name | (First, Middle, | | | es Govern |
| s merked other than | ToB | Benjamin F. Ro | oe. | | | | Mary E. | Metter | | , | |
| S TIE | | 19a. Informant's Name/Relationsh | | 19b. | Malling Address | (Street | end Number or Rure | | | Stete, Zip (| Code) |
| em 27 i | | | ger-Sister | 2 | 736 Arno | ott | Street, S | an Dieg | o, Cali | forni | a 92110 |
| or ot | | 20a. Method of Disposition 1 Bunal 2 Cremation | 3 □Removal from Stat | 20b. Placa of | Disposition (Nerr v, cremetory or of | ne o/ | | Date | 20c. Location - | City or Tow | n, State |
| tant | | 4 Donetion 5 Other (Sp | | Fort I | incoln | | | -6-99 | Brentwo | ood, M | aryland |
| Important: If any Injury o | | 21. Signature of Funeral Service L | Johnson | J | Fort Li 3401 BI | d Addres Inco ader | ss of Facility In Funera Isburg Rd. | l Home , Brent | wood, N | Maryla | nd 2072 |
| | | 23a. Pert1. Enter the disease, or shock, or heart feilure. List | complications that caus | ed the death. Do n | ot enter the mode | e of dyln | g, such as cardiec o | or respiratory en | est, | | Approximete nterval Between |
| edical aminer | Examiner | Immediate Cause (Final disease or condition resulting in death) | e. # | Spirousion Due to (or es a co Due to (or es a co Due to (or es a co | onsequence of): | ieur | nonia | | | | |
| g physicie es the bu | edical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c | Due to (or es e co | | | | | | | |
| ed for | sicia | Pert II. Other significant condition | ns contributing to death | but not resulting In | the underlying ca | ause give | en In Part I. | 23b. Did to | obacco use cor | ntribute to t | he cause of de |
| deteched i | by Physician/N | | stive - | Heart | _ / | ilu | | 1□Y | 08 2 No | 3 Probe | bly 4□Unkr |
| 58 | eted | U | | | V | | | 24e. Was a | in autopsy med? | evail | autopsy findin able prior to pletion of cause ath? |
| nes been signed to a Should be det | n D | | | | | | | 1 □ Y | es No | 10 | Yes 2□ No |
| ate hes been s page 2 should | Completed | | | | | | | | | | |
| artificate hes been sector, page 2 should | Be | 25. Was case referred to medical examiner? | Hospital: | | | Oth | 26. Place of Death | | | | |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day **Physician** REGINALD **BOWMAN** MARCH 26, 1999 3:00 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. Yrs. 577-76-0368 44 Director FEB. 20,1955 WASH., Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be or thems 23s 5041 C STREET, SE 20019 U.S.A. Funeral 14. Race - Amarican Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 72 hours after 1 Yas 2 No If Yes, Give Year or Dates: 1 Naver Married 200 Married 1 ☐ Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th SALESMAN marked other 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental Pages 1 and 2 should be WILLIAM **BOWMAN** GLORIA BRIDGEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra ALMETA BOWMAN - SISTER 8233 FRESNO LANE, T-1 ALEXANDRIA, VA 22309 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 8-99 BELTSVILLE, MD 21. Signature of Funeral Service Licer 22. Name and Addrass of Facility
TAYLOR'S FUNERAL HOME NORTH CAPITOL ST., 1722 NW WASH.DC 20001 24a. Part1. Enter the disease, or confolication that daused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner physicien and the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy been monene completion of cause of death? The lew has 9 2 page certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific. director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigetion rector: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who ALGARUE ST. 8006 191

State Registrar

31. Date filed (Month, Dey, Year) APR 0 8 1999

2. Registrer's Signature

the state of the s

Yrs.

10c. City, Town or Location

Glenarden

26

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day Brooks 2, 1999 0619 AM APRIL 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PEIDMONT & CHURCH STREET GLENARDEN PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days Months

Hours

Dec, 6, 1972

10a. Citizen of What Country?

14. Race - Amarican Indian,

Black, Whita, atc.

Specify: Black

16b. Kind of Businass/Industry

20c. Location - City or Town, Stata

U.S.A.

None

Wash, D,C,

10d. Inside City Limits

Approximata Intarval Between Onset and Death

24b. Were autopsy lindings available prior to completion of cause of death?

2□ No

1 Vyas

redmont & Church Str

1 X Yas 2 □ No

Physician /Medical Examiner

Kareem

KAREEM N. BROOKS

The law requires that the deeth certificate be executed burial-tran the 10 USB (8 has page 2 certificate Attending Physician: director, this funeral s after de. al Director: After filled in by ŏ To the Hospital or within 24 hours at To the Funeral D completely

5. Social Sacurity Number **Funeral** 214-13-5129 Director Usual Rasidence of Dacedent 10a Stata 10b. County Md. Director 28a-f 8 238 Funeral Herra: 11. Marital Status Pages 1 and 2 should be illed within 72 hours after ment of Health and Mental Hypiere.

Int. If Item 27 is marked other than "natural," or the iry or other traumatic event, the Medical Example iry or other traumatic event, the Medical Example 21215-0020 þ Completed 10 Baltimore, Maryland Be Department of Important: If any Injury or **Physician** /Medical disaasa or condition rasulting in death) Examiner Examiner Box 68760, Physician/Medical P.0. Division of Vital Records, þ Be Completed Certification: To XX Yas 2 No 27. Manner of Death 1 Natural 2 Accidant 6 Could not be determined 3 ☐ Suicide 4 Momicida edical 29a, Certifier (Check only

Prince Georges 10e Street and Number 20a. Method of Disposition Immediata Causa (Final Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in daath) Last

Elementary/Secondary (0-12)

10f. Zip Code 20706 3214 Hayes Street 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Navar Marriad 2 ☐ Merried 1 Yas 2 No Specify: 3 Widowed 4 Divorced Vaar or Datas 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Collega (1-4or 5+) Unemployed 17. Fathar's Name (First, Middle, Last) 18 Mothar's Nema (First Middle Maiden Sumama) Carolyn W. Jones Lyntellus Brooks Jr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 3214 Hayes St., Glenarden, Md. 20706 Carolyn Brooks Newsome 20b. Place of Disposition (Name of cematary, cremetory or other place) Data 11 Burial 2 Cramation 3 Ramoval Irom Stata 4 Donetlon 5 Other (Specify) 4-8-99 Clinton, Md. Forest Hill Ceme. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Phillip Bell Funeral Seryic 4902 Stan Haven Rd., Temple Hills, Md. 23a. Part 1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab and Cutting Would Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa ralarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Rasidence XXOthar (Specify) AT SCENE 28a. Data of injury
(Moeth, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation

tnjung AM 4-2-99 28a. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) park

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Chief Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Chief Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) APRIL 3, 1999

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

Glenarden, Id

1 TYes 2 □ No

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

Churt .

111 Penn Street, Baltimore, Maryland 21201 lennis hutemo

31. Date liled (Month, Day, Year) APR 0 8 1999

29b. Signatura and titla of certifian

Denn

one)

37. Registrar's Signatura

State

Registrar

interest to the state of

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth **Physician** Kelly Barnes 1999 APRIL /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Doctor's Hospital Prince George's L.anham Months Days Hours Min. 8. Date of Birth Man 24, Y9906 5. Social Security Number 9. Birthplace (State or Foreign Virginità 7. Aga (In yrs. last birthday) **Funeral** 1€M 2□ F 579-18-9559 93 Yrs Director Usuel Residence of Decedent the Meryland 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23s or 28s-f show treumstic event, the Magical Examiner must be noutled at Yes 2 No Director Mary land Prince George's Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiena.

Wher than "netural", or items 23a or ? 9107 South Cherry Lane 20747 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Never Married 2 ☐ Marriad ∏Yas 2 No fYas, Give Year or Dates: 1 ☐ Yas 2 VNo Specify: Specify: Black 3AWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) 3rd grade Collaga (1-4or 5+) Carpenter Self-Employed 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) . Pages 1 end 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other treumatic even Be John Barnes, Sr. Lela Barnes 19a. Intorment's Neme/Raletionship (Type, Print)
Mr. Jerry M. Barnes (Nephew) 19b. Mailing Addrass (Street and Number or Flural Floute Number, City or Town, State, Zip Coda) 1612 40th Street, S.E. Washington, D.C. 20020 20b. Placa of Disposition (Name of cemetery, cremetory or other place)
Forest Hills Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removel from Stata permit. Page Department o important: If any injury or 4/8/99 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licenses 22. Name and Address of Fecility Rollins Funeral HOme, Inc. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximately a such as cardiac or respiratory errest,

Approximately Approximate Interval Between Onsat and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical · Athnosclerotic Fleat Di Stare Examiner Dua to (or as a consaguence of):

hnosclenosis Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury thet initiated evants resulting In deeth) Last and P.O. Box 68760, Physician/Medical Due to (or as e consequanca ot) been signed by the e should be detached f Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 25 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, þ 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy performed? Completed page 2 certificate 1 ☐ Yas 2 ☑ No To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific. 25. Was case rafarred to medical examiner? Be 26. Placa of Daath (Check only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manpar of Death 28b. Tima ot 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 2 Accidant 5 Pending 1 TYes 2 No Investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicida 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date end place, and dua to the ceusa(s) end mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the tima, date and place, and dua to the cause(s) and manner stated. 29a, Certifia 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. Licanse number ano/ 30. Nama and address of person who complated causa ot death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Galant Fox Lane Suite 222 Bowie, Maryland 20715 31. Dete filed (Month, Dey, Yeer)
APR 0 7 1999 State Registrar

Arona, A

| | 1. Decedent's Name (First, Middle, Las | st) | | |) e i i | | 2. Date of D | | Winn | 3. Time of Death |
|---|---|---|--|---|--|--|---|--|--|--|
| sician edical | ALEXANDER | BARNETT | | | | | Month 04 | O2 | Year 99 | 1:30pm |
| miner | 48 Facility Nama (If not institution, giv. | a street and number) | | | | 4b. City, Town, or | Location of Dea | th 4c. Count | y of Death | |
| | PINEVIEW NURSING | | | Wat- | 14-1/ | CLINTON | | PRING | | ORGES |
| ral | 5. Social Security Number 6. S 218–09–1521 | 6ex 7. Ag | ge (In yrs. lest) 84 | Yrs. If Und | er 1 Year S Days | | (Month, D | ey, Year) | 9. Birthe | place (Stata or Foreigntry) |
| tor | Usuel Residence of Decedent | | - | | | | variuary | 21, 1915 | Mary. | Land |
| | 10e. State 10b. County | | 10c. City, To | own or Location | | | | | 1 | IOd. inside City Limit |
| eted by Funeral Director | Maryland Prince G | eorges | Upper | Marlbon | ro | | | | | 1 X Yes 2 N |
| Dire | 10e. Street and Number | | | | Zip Code | | | 10g. Citizen of | What Cour | ntry? |
| erai | 5305 Spring Drive | | Ever le II C | | 20772 | | anaih. Van as N | U.S.A. | ce - Americ | nan indian |
| Funeral | 11. Marital Status 1 □ Never Marriad 2 ☑ Married | 12. Was Decedant Armed Forcas? 1 ☐ Yas 2 🔀 | | | | Hispanic Origin? (S pan, Mexican, Puerl | to Rican, etc.) | Ble | ick, White, | |
| by | 3 ☐ Widowed 4 ☐ Divorced | if Yes, Give Year or Dates: | | 1 ☐ Yes | 2 <mark>≧</mark> No | Specify: | | Specil | y: B1 | ack |
| Completed | 15. Decedent's Ed (Specify only highast gra | ducation | 16 | Se. Decedent's Us | sual Occu | petion during most of worded) | rkina | 16b. Kind of B | Business/In | dustry |
| h | Elementary/Secondary (0-12) | College (1-4or | 5+) | | | | | | | |
| | 10th | | | Houseke | eepir | ng Leader | | Govern e, Maiden Sumer | | |
| Be | 17. Fether's Name (First, Middle, Last) | | | | | | | | me) | |
| To | Richard Barnett 19a. Informant's Name/Relationship | Tyne Print) | 1 | 9h Mailing Addre | es (Straa | t end Number or Ri | ilkerso | | Stete 7in | Code) |
| | Emma Barnett/Wife | | | | | | | | | |
| | 20a. Method of Disposition | | 20b. Piace | of Disposition (A | lame of | OTTAE, DD | Date | 20c. Location | - City or To | and 20772 own, State |
| | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific | | | Carmel C | | 1 | 4/8/99 | Upper Mar | lboro, | Maryland |
| ei e | 21. Signatura of Funeral Servica Licen | 1800 | 1 | 22. Name | and Addr | ess of Facility | | | | |
| | | | | TD | TINITI | DIA DIBIDO | AT TION | | | |
| 8 | Nancry A | Percen | tre | | JENKI | INS FUNER | | ver Mar | cvlan/ | d 20785 |
| 8 | 23a. Part1. Enter the disease, or compshook, or heart failure. List only | Per cent | d the death. D | 7474 I | JENKI Lando | INS FUNER | , Lando | ver, Mar | cyland | Approximata |
| _ | shock, or heart failure. List only | Per centile plicetions that caused one cause on each li | d the death. D | 7474 I | JENKI Lando | INS FUNER | , Lando | ver, Mar arrest, | ryland | d 20785 Approximata Interval Between Onset and Death |
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State Registrar 31. Date filed (Month, Dey, Year)
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82. Registrar's Signature

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Physician /Medica Examine

Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Atlending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

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State Registrar

31. Dete filed (Month, Day, Year) APR 0 5 1999

22. Registrar's Signature

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service service service

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** 12:50 Pm Willie A. Blalock APR /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M AFF 68 Yrs Oct.31, 1930 Washington, DC Director 577-38-6479 Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1√ Yas 2 No Directo District of Columbia Washington 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code with 3513 Holmead Pl., N.W. 20010 USA death v Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black, White, etc. 11 Meritel Status 2 should be filled within 72 hours efter n and Mental Hygiene. 1 Yes 2 No ff Yes, Give Year or Datas: 1 Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Film Assembler permit. Pages 1 and 2 should be file.
Deperment of Health and Mental Hy,
Important: If item 27 is marked other,
any injury or other treumatic event, 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Rebecca John Quincy Royster 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pl., N.W. (Wash., D.C. 20010) Rodney Blalock (Son) 3513 Holmead 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Lincoln Memorial Cem. 4/8/99 Suitland, Md. 22. Name and Address of Facility
Jordan Funeral Service, Inc 4001 Benning Rd., N.E. (Wash., DC20019) 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unit only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical fmmediate Ceuse (Final disease or condition resulting in death) Ureme Examiner Due to (or es e consequence of) Examiner 1d2 ati physician end s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es a consequence of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? ed by the a signed by t Probably 4 Unknown 1 Yee 2 No head and neck cands þ 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? hes 2 No certificete or Attending Physician: 25. Wes cese referred to medical examinar? director Be 26. Pieca of Deeth (Check only one) Hospital: Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 0 this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: Naturel 2 Accident 5 Pending Investigation efter death. Director: Aft d in by the fur 1 Tyes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in 24 hours the Funeral Director of the filled in by 4 Homicide Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signeture and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) D0052381 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Road Silver Spring MS 20910 Forest ROBYN ANDERSON 1500 32 Registrer's Signeture 31. Data filed (Month, Day, Year) State APR 0 5 1999 Registrar

the second of the

200 m : 11.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 102 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death APRIL 5, 1999 3:00pm Brown exome 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death P.G. COUNTY SOUTHERN MARYLAND HOSPITAL CLINTON Hours Min. J. Date of Birth J. Month. Bass. Years 42 6. Sex If Under 1 Year 9. Birthplaca (Stata or Foreign WASHINGTON DC 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 56 579-54-1075 Yrs. Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits TV Yas 2 No SUITLAND PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4303 JOHN ST. 20746 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? ↑EPYes 2 □ No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married Married 1 Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE MAIL HANDLER TECHNICIAN 18. Mothar's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) AMANDA ALLEN GEORGE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4303 JOHN ST. SUITLAND, MD 20746 SUSIE BROWN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State WASHINGTON NATONAL CEMETERY 4-9-99 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility ALEXANDER S. POPE FUNERAL 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Zypus Due to (or as a consequence of): Due to (or es e consequence of) Dua to (or es a consequance of)

permit. Pages 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than *--any injury or other traumest—
DRGs. **Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be

the

with

Director

Funeral

p

Completed

Be

7 1/6

The law requires that the death certificate be executed

has

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice

24 hours

the

completely To the To the To the

Division of Vital Records, P.O. Box 68760,

ng physician and es the bunal-transit attending USB ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed to à should b

Physician/Medical Examiner Completed certificate ha Be To

Certification:

edical

29a. Certifier

29b. Signature

Sequentially list conditions, if any, laading to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last

25. Was cese referred to medical examiner? 1 Yas 2 No 27. Manner of Death 1 ☐ Neturel

5 Panding invastigation 2 Accident 6 Could not be determined 3 Suicide 4 | Homicide

of certified

Hospitel: 1∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

28d. Describe how Injury occurred

24a. Wes en autopsy performed?

1 Yes 2 XNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

APRIL 8,1999

23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☐ Yes 2 ☐ No

10 Carditying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Hedical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

rson who completed cause of deeth (Item 23a) (Type, Print)

SHARON MARSELAS M.D. 12070 OLD LINE CENTRE SUITE 205 WALDORF, MD 20602 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature APR 0 8 1999



D 22026

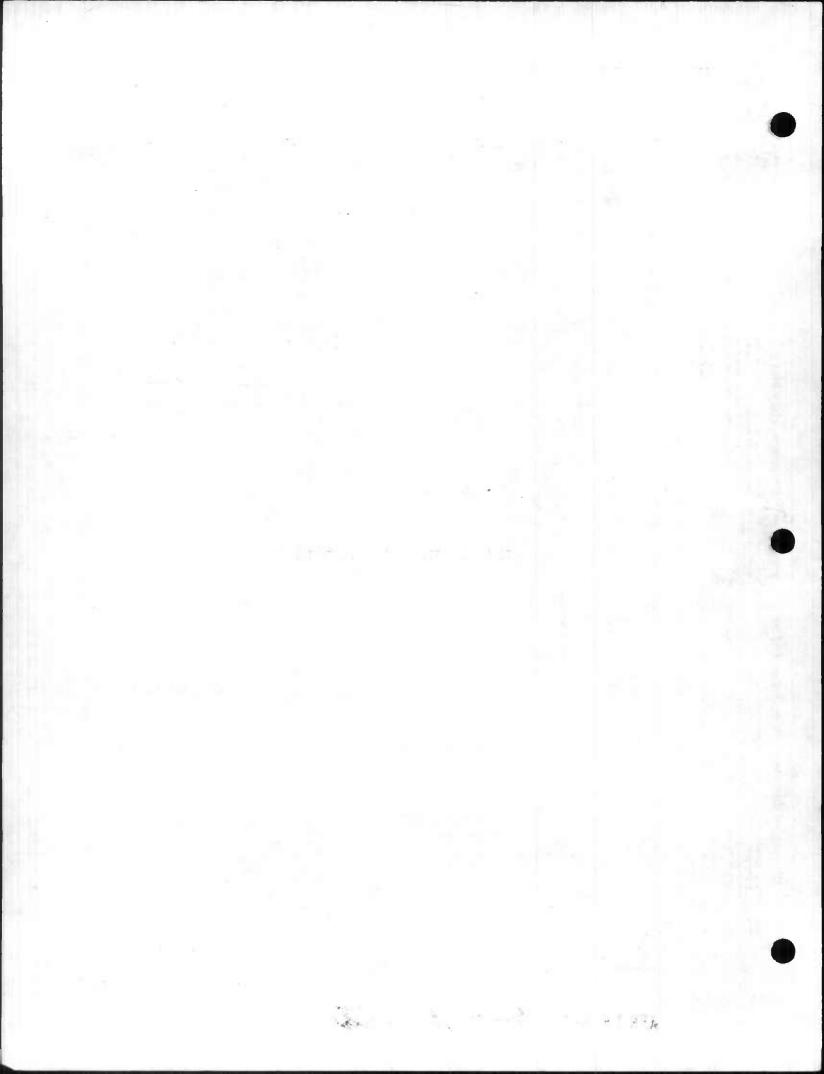
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| | 's Name (First, Middle, Li | aryland / -23-99 WR. | 2. Date of Dea | th | 3. Time of D | | | | | |
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| Lui | s Antonio | o Burgos | 3 | | | Month APRII. | 11 190 | Year 9:20A.1 | | |
| | lame (If not institution, gi | ve street and number) | | | 4b. City, Town, | or Location of Death | 4c. County | | | |
| WASHI | NGTON ADVENT | TIST HOSPIT | ſAL | | TAKOMA | PARK | MONTO | COMERY | | |
| | | | ge (In yrs. last bi | Months D | | rs. 8. Date of Birth | Year) | 9. Birthplace (State or a Country) | | |
| | 27 0722 | 1 □ M 2 □ F | 39 | Yrs. | | 11-29 | 1-59 | Bolivia | | |
| Usual Resid | ence of Decedent 10b. County | | 10c. City. Tox | vn or Location | | | | 10d. Inside City | | |
| MD | Montgo | mery | | Takoma P | ark | | 1 ☐ Yas 2 | | | |
| 10e. Street | and Number | | <u> </u> | 10f. Zip Co | de | 1 | 0g. Citizen of W | | | |
| 11, Marital S | | ton , Lane | e | 101. 249 00 | 20912 | | Bolis | | | |
| 11. Marital 3 | Ratus | 12. Was Decedent | Ever in U,S. | 13. Was Decedent | of Hispanic Origin? | (Specify Yes or No- | 14. Race | e - American Indian, | | |
| 1 | er Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☑ | | La contract of the contract of | | (Specify Yes or No- erto Rican, etc.) | Blac | k, White, etc. | | |
| | owed 4 Divorced | If Yes, Give Year or Dates: | | XIX Yes 2□ | No sparing li | vian | Specify | hite | | |
| 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of | | | | | | undring | 16b. Kind of Bu | siness/Industry | | |
| Elementa | ry/Secondary (0-12) | College (1-4or 5+) | | life. DO NOT use, n | one during most of verticed). Cal Tech | vorking | Comme | ercial | | |
| Elementa | | 4 | | FIECUL | car reer | | | | | |
| 17. Father's | Name (First, Middle, Last | 0 | | | | iame (First, Middle, | | (0) | | |
| 17. Fathers | | Luis Bu | rgos | | Blanca 1 | rteaga | urgos | | | |
| 19a. Inform | ant's Name/Relationship | | 19 | b. Mailing Address (S | reet and Number or | Pike Arl | City or Town, | State, Zip Code) Va 22204 | | |
| | Keiro Sort | o Gonzal | | 3700 00 | | | ~ | | | |
| 1 DXBu | of Disposition ial 2 Cremation 3 Dation 5 Other (Speci | | Cate | of Disposition (Name of the OT Heav | en (| 4-16-99 | 20c. Location - Sil | City or Town, State Verspring | | |
| | of Faperal Service Lice | | | 20 Name and A | ridraes of Facility | | T | 1 Commico | | |
| A | O Philis | 7/11/11 | 2111 | - Ivanio and A | S | terling | Funera | l Service | | |
| - | Enter the disease, or corr | 10 cm | | | | | | DC 20019 | | |
| Sequentially if any, leading cause Ent | list conditions, no to immediate or Underlying | | | 1 | | | | | | |
| Cause (Disc that initiated | exents | C | Due to (or as a | consequence of): | | | | | | |
| Part II. Othe | leatri) Last | d | | | | | | | | |
| Port II Other | significant conditions of | pontributing to double by | ut not ensulting | in the underhine sauce | a given in Doct I | 22h Dida | phacon use con | ntribute to the cause of | | |
| | -gamen constitute (| A STRUCTURE TO GOOD D | or not resulting | ar are underlying caus | o given at Felt I. | | | 3 Probably 4 BU | | |
| | | | | | | _ | -3 ZLI 140 | -2 | | |
| | | | Ēģ. | | | 24a. Was a perfor | | 24b. Were autopsy fir available prior to completion of ca of death? | | |
| | | | | | | 104 | es 2□No | 1 Yes 2 N | | |
| | e referred to medical | | | | 26. Place of I | Death (Check only or | | | | |
| 25. Was cas | | Hospital: | ent 200 ER/O | utpatient 3□ DOA | Other | Home 5 Resid | | er (Specify) | | |
| 25. Was cas | ? 2□ No | | ry 28b. | | | 28d. Describe h | | | | |
| 25. Was cas examine 1 🖾 Yes 27. Manner | ?? 2 No of Death | 26a. Date of Inju | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 26a. Date of Injury (Month, Dey Year) 28b. Time of Injury 8 | | | | | | | |
| 25. Was case examine 1 🔀 Yes 27. Manner 1 🖄 Natu 2 🗌 Acc | ?? 2 No of Death ral 5 Pending dent investigatio | (Month, Da) | , , , , , | М | | | 28f. Location (Street and Number or Rural Route Num | | | |
| examine 1 🖾 Yes 27. Manner 1 🖾 Nati | 2 No of Death ral 5 Pending dent investigatio ide 6 Could not b | (Month, Da) | ury - At home, fo | arm, sireet, factory, of | | 28f. Location (S City or Town | n, State) | | | |
| 27. Manner 1 Nath 2 Acc 3 Sui | 2 No of Death ral 5 Pending dent investigatio ide 6 Could not b | (Month, Da) | ury - At home, fo | | | 28f. Location (S City or Town | n, State) | | | |
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| examine 1 X Yes 27. Manner 1 Nat 2 Acc 3 Sui 4 Hor 29a. Certific (Check one) | 2 No | 28e. Place of Injudicing, etc. 28e. Place of Injudicing, etc. 1994 clan: To the best of miner: On the basis of and manner sta | of my knowledge examination ar ated. | arm, street, factory, of e, death occurred at the door investigation, in 29c. Li | ne tima, date and pla my opinion, death oc cense number . C.M.E. | City or Town | n, State) ause(s) and ma ate and place, a 19d. Date signed | and due to the cause(s) d (Month, Day, Year) | | |

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Registrar

29b. Signature and title of certified

31. Date fited (Month, Day, Year)

APR 0 6 1999

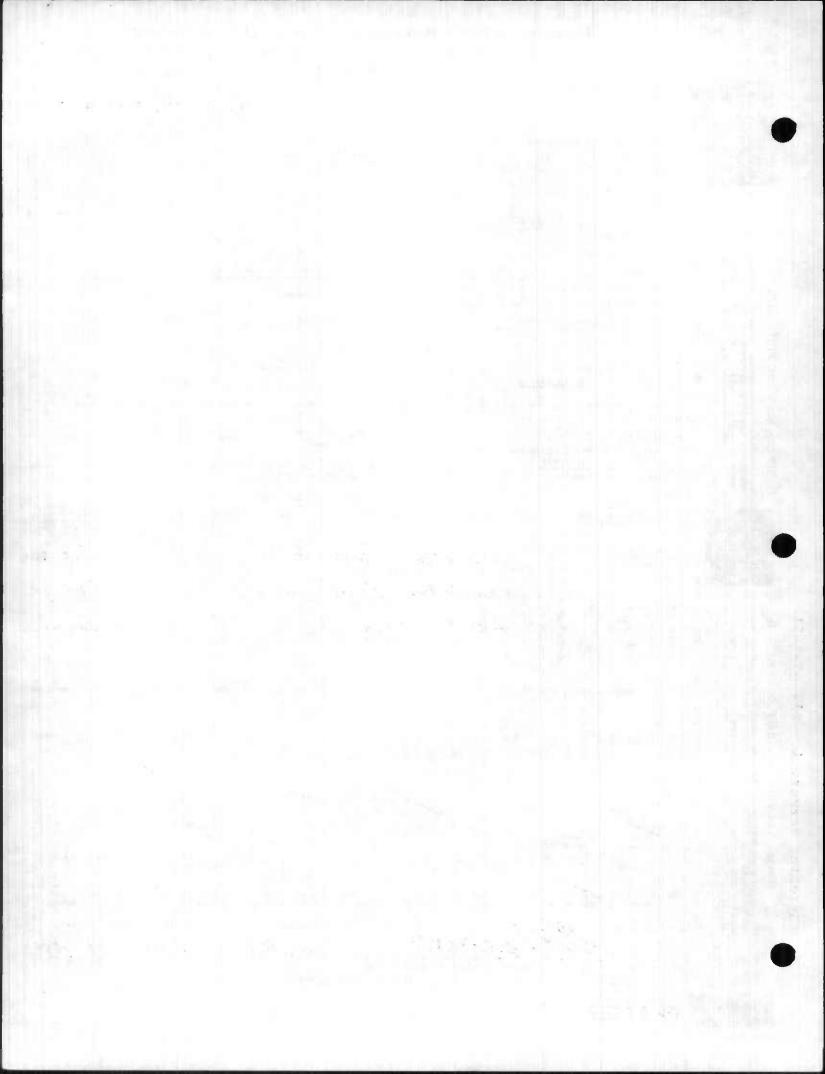
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Wagoner, M.D.; Bishop Walsh Drive; Cumberland, MD 21502

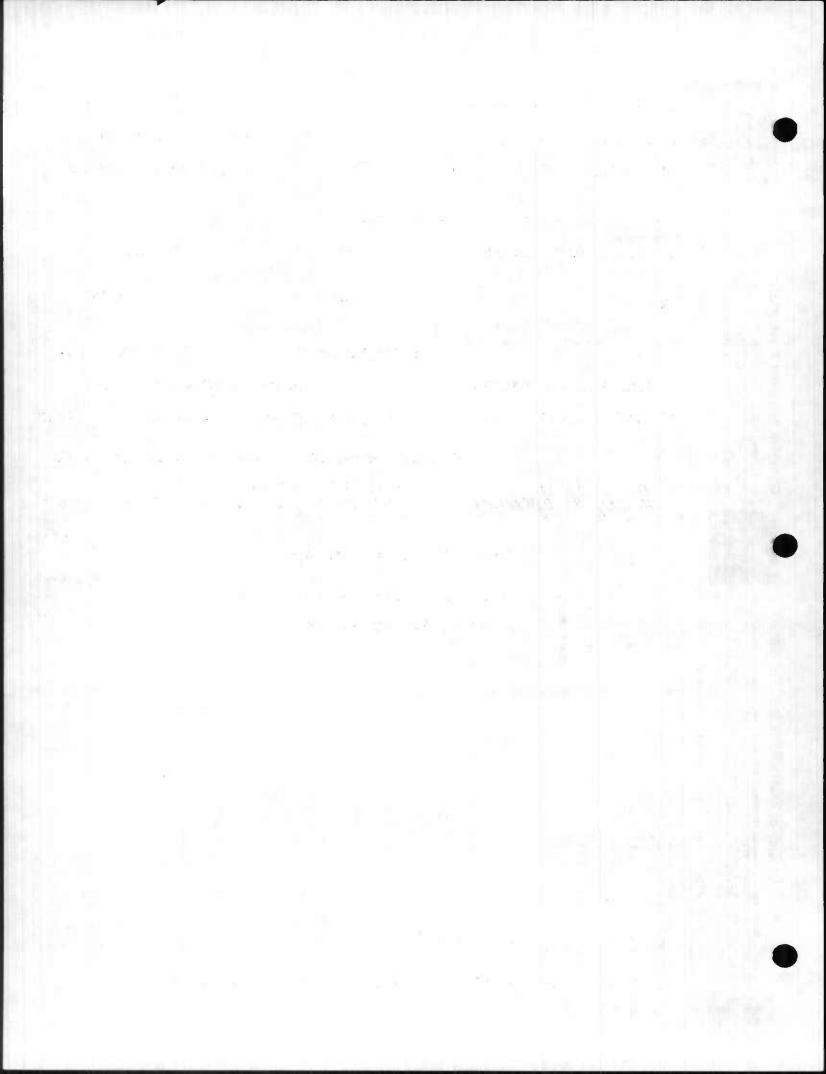
32. Registrer's Signeture

Herbert

ramble,

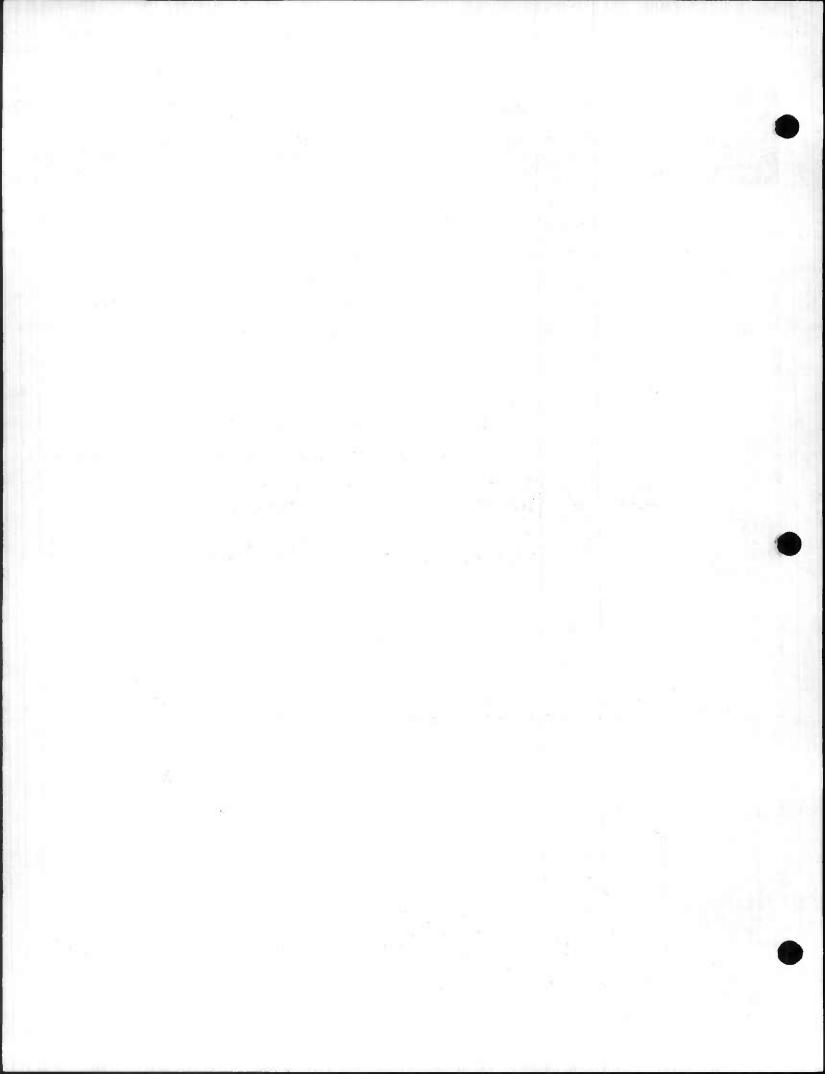


| | | Decedent's Name (Firs | t Middle I se | () | | Ce | ertificate | of | Death | 2. Date of D | Reg. No. | 0 | 3. Time o | of Daeth | |
|---|--|---|--------------------------|--|----------------------------------|--|--|-----------------|---|---------------------------------------|---------------------------------|-----------------------------|--|------------|--|
| Physiciar /Medica | | VINCENT | W. I | P. BE | CKER | | | | | APRIL | 9 , 1 | 999 | 8:45 | | |
| Examine | r | 4a Fecility Name (If not in SACRED HI | | | | | | | 4b. City, Town, or i CUMBER | | | nty of Death | | | |
| Funeral Director | | 5. Sociel Security Number 21 4-05-612 | 5 7 | ox ZM 2□F | 7. Age (In yr. 90 | s. lest birthdey Yrs. | Months | Year Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Bi (Month, D DEC • 1 | 7, 1908 | 9. Birth Cou MAR | place (Stete entry) YLAND | or Foreign | |
| aryland show | 1 | 17.2 | County | | | City, Town or L | | | | | | | 10d, Inside C | | |
| with the Maryler or 28s-f show | 000 | | ALLEGA | ANY | C | UMBER | 1 | 2-4- | | | 10- Ohio- | (1100-1100-11 | 22 | 2 No | |
| th with the state or 3 | | 13 S. ALI | LEGANY | STRE | ET | | 10f. Zip (| 150 |)2 | | U.S. | | | | |
| urs efter dee | 2 | 11. Meritat Status 1 □ Never Married 2 3 ☑ Widowed 4 □ D | | 12. Wes Dece Armed For 1 Yes If Yes, Giv Year or D | rces? 2∑No ve | U,S. 13. | Was Decede If Yes, special 1 Yes 2 | fy Cubi | lispenic Orlgin? (S an, Mexican, Puert Specify: | pecify Yes or N o Rican, etc.) | 8 | lace - Ameri lack, Whita | , etc. | | |
| | Be Completed | 15. D (Specify onl) Elementary/Secondary | | ucation de completed) College (| 1-4or 5+) | (Give | edent's Usuet e kind of work DO NOT use TE FO | done retire | during most of wor d) | king | 16b. Kind of | | A CO. | | |
| | | 17. Fether's Neme (First, | | | | 1100 | 12 10 | | 18. Mothar's Nan | na (First, Middle | , Maidan Sum | ame) | | | |
| Mid yidlid 2 should be file h and Mentel Hy is marked oth reumatic event | | CASPER M | | | ER | | | | | L. HO | | | | | |
| rt tr | | 19a. Informent's Neme/R MICHAEL I | | | N | | - | | and Number or Ru GANY ST | | | | | 02 | |
| Delitimore, in permit. Pages 1 and Jepatiment of Health important: if Item 27 any Injury or other it page. | 20a. Method of Disposition 1 \(\tilde{\mathbb{N}} \) Burial 2 \(\tilde{\mathbb{C}} \) Cremetion 3 \(\tilde{\mathbb{R}} \) Ramovel from State 4 \(\tilde{\mathbb{D}} \) Donetion 5 \(\tilde{\mathbb{C}} \) Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 \(\tilde{\mathbb{D}} \) Dete 20c. Location - (Cemetery, crematory or other place) 4 \(\tilde{\mathbb{D}} \) Dete 20c. Location - (Cemetery, crematory or other place) | | | | | | | | | | | | D | | |
| minicate be executed ing physician end es the buriel-transit | enical | Immediate Cause (Finat disease or condition resulting in death) Sequentially list condition if eny, leading to immedia cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last | | b. Atı | Due to | (or es e conse ribril (or es e conse y Arte (or as e conse | equence of): latic equence of): ery Di | n | | | | | yea yea | | |
| law requires that the deeth certificate see signed by the attending as should be detached for use as an interest by Physician Ma | | | | | | | | | | | contribute to the cause of deat | | | | |
| The law requires to take has been signed page 2 should be common to the | hickory | | | | | | | | | 24a. Wa | s an autopsy ormed? | 9 | Vere eutopsy vallable prior ompletion of daath? | to | |
| = = = = = | | | | | | | | | | | Yes 2KIN |) 1 | ☐ Yes 2☐ |] No | |
| | 0 | 25. Wes case referred to exeminer? 1 ☐ Yes 2 ☒ No | - | Hospitei: | Inpatient 21 | ☑ ER/Outpetie | ent 3 DO | Oth | 26. Pleca of Dec ner: 4 Nursing h | oth <i>(Check only</i> Iome 5□ Res | | Other (Spec | rify) | | |
| E per e | | 27. Mannar of Deeth 1 💆 Naturet 5 🗆 2 🗆 Accident | Pending Investigation | 28e. Dete | | 28b. Time of Injury | of 28 | c. tnju Wor | y et rk? Yes 2 □ No | 28d. Describe | how injury oc | curred | | | |
| To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification: | | 3 ☐ Suicide 6 ☐ 4 ☐ Homicida | Could not be determined | | of Injury - At ng, etc. (Spec | home, farm, s | treet, factory, | office | | 28f. Location City or To | (Street and Nu own, Stete) | mber or Ru | ral Route Nur | nber, | |
| To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by Medical Certifi | Palical | | | ner: On the b | | | | | ma, data and place opinion, daeth occu | | | | | s) | |
| To the comp | | 29b. Signatura and title of | certifier | mi | , v | ns | | Licens 0 3 4 | e number 159 | | 29d. Date sig | | , Dey, Year) , 1999 | | |
| ms | | 30. Neme end eddrass of R. ESPINA | | | | | | CI | JMBERLAI | ND, MD | 2150 |)2 | | | |
| State Registrar | | 31. Date filed (Month, Pay APR 12 | 1999 | 12/ | legistrar's Sig | | | | | | | | | -1 | |



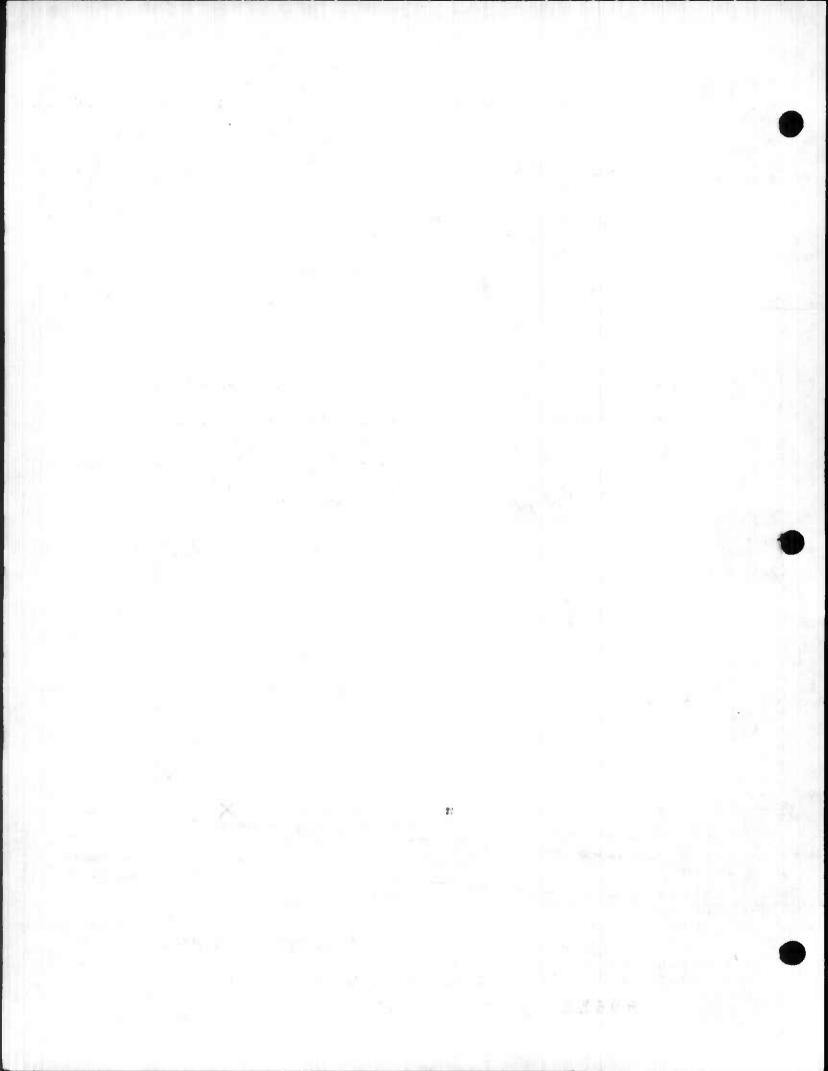
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Cen | tificate of | Death | , | Reg. No. | 9 | 12000 | |
|-------------------|---|----------------|---|--|------------------------------|-----------------------------|--|---------------------|---------------------------------------|--------------------------------------|-----------------------------|--|--|
| | Physic | ion | 1. Decedent's Name (First, Middle, Las | st) | | | | | 2. Dete of De Month | ath Day | Year | 3. Time of Death | |
| | Physic /Medi | | DOROTHY VIRGINIA | A BOSLEY | | | | | Apri | 06 | 1999 | 2:15 AY | |
| | Exami | | 4a. Fecility Name (If not institution, give | | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | |
| | | | MAUST PERSONAL CA | | | | | ACCIDENT | | GARRETT | | | |
| | Funeral Director | | 5. Social Security Number 6. S 220-10-0227 1 Usual Residence of Decedent | ex 7. Ag | e (In yrs. last 87 | Yrs. | Months Days | | | | 9. Birthpi Count | lece (State or Foreign try) PA. | |
| | Meryland -f show | | 10a. State 10b. County | | 10c. Cify, To | own or Loc | ation | | | | 10 | 0d. tnside City Limits | |
| | | | MARYLAND GARRETT | r | ACCT | DENT | | | | | | 1 ☐ Yes XIX No | |
| | r 28a-f | Director | 10e. Street end Number | | ACCI | DENI | 10f. Zip Code | | | try? | | | |
| | th with | | 143 AIKEN MILLER F | ROAD | | | 2152 | 0 | | U.S. | Δ | | |
| 21215-0020 | ter dee | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Xidowed 4 Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes: | | If | 13. Was Decedent of Hispenic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☐ No Specify: Decedent's Usual Occupation (Give kind of work done during most of working lifte. DO NOT use retired) | | | - 14. Rac Biad | e - America ck, White, e | etc. | |
| 5-0 | 72 ho | ted | 15. Decedent's Ed (Specify only highest gra | | 11 | 8e. Decede | | | | | Business/Industry | | |
| 21 | within ene. | Completed | Elementery/Secondery (0-12) | College (1-4or 5 | i+) | | | | irking | | | | |
| | filed within Hygiene. | Co | 12 | | | HOUSE | E KEEPER | | | HOUSE I | | R | |
| Maryland | should be filed nd Mental Hygi marked other imatic event, | Be | 17. Father's Neme (First, Middle, Last) | | | | | 18. Mother's Na | me (First, Middle, | Meiden Sumem | 10) | | |
| Z | should nd Men marke | To | JESSE SMITH 19e. Informant's Name/Relationship (7) | 5 O-1211 | | | | ANNA TE | | | | | |
| Ma | 0 0 0 0 | | ANNA BUCKINGHAM | | | | | t end Number or R | | | | Code) | |
| e, | of Health Item 27 other tr | | 20a. Method of Disposition | DAUG | 20b. Place | of Dispos | X# 156 Ition (Name of | Ţ | MARYLAN Dete | D 2154 20c. Location - | | wn State | |
| Baltimore, | Pege nent o ant: If I | | Burial 2 Cremation 3 4 Donation 5 Other (Specify | Removal from State | | | CHRISTIA | N CEMETE | | | 1999 INGLESMITH PA. | | |
| Bal | permit. Per Departmen Important: any injury once. | | 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | | | | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | that caused | the death. D | o not enter | the mode of dy | UR_STREE | T CUMBER or respiratory a | LAND MAI rest, | | Approximate | |
| | Physician /Medical Examiner | | tmmediete Cause (Final disease or condition resulting In deeth) | . Conge | -1.0 | - | tean- | | ilme | | | Interval Between Onset and Death | |
| _ | n # | ner | | O | Due 10 (01 43 | a consequ | orico orj. | | | | 1 | | |
| | death certificate be executed e ettending physician and od for use as the buriel-transit | Examiner | Sequentially list conditions, | b | Due to (or es | e consequ | ence of): | | | | | | |
| 60, | cian a | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | C | | | | | | | | | |
| 68760, | physi the | Medicai | that Initiated events resulting in death) Last | | Due to (or as | e consequ | ence of): | | | | | | |
| | ding ph | | L. | d | | | | | | | | | |
| Box | eath ce ettendi | ciar | | | | | | | | | | | |
| Ö | | Physician/ | Part II. Other significant conditions co | g in the underlyIng cause given in Part I. 23b. D | | | | | | the cause of death? | | | |
| a | g g | by P | HIZheime | us de | mat. | ia. | | | 10 | Yes 2 No | 3 Prob | ably 4 Unknown | |
| of Vital Records, | ew requir | Completed b | | | | | | | | an eutopsy rmed? | con | re eutopsy findings illeble prior to npletion of cause death? | |
| E F | The ate | Co | | | | | | | 101 | es 2 No | 1 🗆 | Yes 2□ No | |
| Vita | ysician: The s certificate director, par | Be | 25. Was case referred to medical examiner? | Hospital: | | | 100 | | ath (Check only o | ne) | | Market Survey Control of the Control | |
| of | this aldi | . To | 1 Yes 2 No 27. Menner of Death | 1 ☐ Inpatie | | Outpatient | 3LI DOA | | Home 5 Resid | | er (Specify |) | |
| | ing Atte | tion | 1 Maturel 5 ☐ Pending | (Month, Da) | Year) | b. Time of Injury | 28c. Inju Wo | nrk?]Yes 2∐No | 28d. Describe i | now injury occurr | өа | | |
| Division | C 0 : 0 | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Plece of Injubuilding, etc | | farm, stree | | | 28f. Location (S City or Tox | Street and Numb m, State) | er or Rural | Route Number, | |
| ā | To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th | edicai C | 29a. Certifier (Check only one) 1 Certifytng Phy 2 Medical Exam | etcian: To the best of iner: On the basis of | of my knowled examination | ige, deeth o and/or inve | occurred at the ti | ime, date and place | e, and due to the curred at the time, | cause(s) and ma date end place, a | nner as sta | ated. the cause(s) | |
| | o the o the omple | Med | 29b. Signature end tille of certifier | | /// | 1 | 29c. Licen | se number | | 29th Date signed | d (Month f | Day, Year) | |
| | F 3 F 8 | ~ | 1 6 | 15 6 | // | mo | | | | (1) | 01 | 1000 | |
| |) | | 30. Name and address of name who a | omplated source of d | agth (Ham 22 | | | 1 340' | 17 | Tipol | 06 | 1777 | |
| | nis | | 30. Name and address of person who o | = , be ! | tre | l p | | Frantsu. | ile M | n a | 153 | 6 | |
| | Sta Registr | | 31. Date filed (Month, Day, Yeer) | Sa. Hegistra | r's Signeture | . A | THE PARTY | / | | | | | |



State of Maryland / Department of Health and Mental Hygiene

| | - | 1. Decedent's Name (First, Midd | de Last) | | | | | 2. Dete of De | Reg. No. | - | 3. Time of Dec | |
|---|-----------|---|-----------------------|--|--|--|--|--|--|--|--|--|
| Physician | - | Florence Eliz | | adwater | | | | April | 2 Del 1999 | Yeer | 7:30 p. | |
| /Medical | - | 4a. Facility Name (If not institution | | | | | 4b. City, Town, or L | p.ar. | | | 7.50 p. | |
| Examiner | | 47 Red Bird L | | | | 1 | ett | | | | | |
| uneral irector | | 5. Social Sacurity Number 373–34–7334 Usuel Residance of Decedent | 6. Sax 1 □ M 2 🕅 F | 7. Aga (In yrs. 77 | lest birthday) Yrs. | If Under 1 Yaar Months Deys | If Under 24 Hrs. Hours Min. | 8. Data of Birt (Month, Pa June 15 | y, year) 1921 | 9. Birthple Count | eca (Steta or Fo | |
| how | | 10a. State 10b. Count | у | 10c. Ci | ty, Town or Lo | cation | | | | 10 | Od. inside City Li | |
| 28a-f show critied at | 2 | MD Garr | ett | Lona | aconing | 5 | | | | | 1 ☐ Yes 2 🖟 | |
| 2 2 2 | N DIE | 10e. Street end Number 47 Red Bird L | ane | | | 10f, Zip Coda 21539 | | | 10g. Citizen of V USA | Whet Count | try? | |
| ons. than "natural", or forms than "natural", or forms that Medical Examinar in mpleted by Funel | 2 | 11. Marital Status 1 ☐ Nevar Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce | Armed Fo | 2 No | i | Nes Decedent of Hispanic Origin? (Specify Yes or I f Yes, specify Cuben, Mexican, Puerto Rican, etc.) I □ Yes 2 1 No Specify: | | | 14. Rad Bled | ce - America ck, White, e y: Whi | etc. | |
| | Completed | (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 1.2 College (1-4or 5+) | | | | ent's Usuel Occup kind of work dona 00 NOT use retire | oation during most of worl d) | 16b. Kind of Br | | Business/Industry | | |
| martic ever | | 17. Fethar's Neme (First, Middla | , Lest) | | | - | 18. Mothar's Nam | e (First, Middla, | Maiden Sumen | ne) | | |
| | | David W. Weir | | | | | Lillie H | florence | Green | | | |
| | | 19e. Informent's Neme/Relation | | -l 1 | | | end Number or Ru | | | | Code) | |
| m 27 her tu | - | Graydon Broad 20e. Method of Disposition | water nus | | | | ane, Lona | pril 6 | | | | |
| nt: If its | 1 | 1 Donation 5 □ Other (| | State | | sition (Neme of netory or other ple | | 1000 Mills, MD | | | | |
| Important: If Iem 27 is any injury or other trau pncs. | | 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Eichhorn—McKenzie Funeral Home P.A. | | | | | | | | | | |
| | + | 23a. Part J. Enter the disease, or heart feilure. Lis | Mikene | accord the decad | Lo | naconing | , MD 2153 | 39 | | | | |
| | | immediete Ceuse (Finel | No. | -16507 | TT | 4.44 | na 11 | / | | İ | Clur 1. | |
| miner muliuer | | disease or condition resulting in deeth) | e. ME | Due to (c | or es a conseq | uenca of): | om of c | OLD W | | | FIVE YE | |
| i j | | disease or condition resulting in deeth) | e. ME | Due to (c | | uenca of): | om of c | OLD W | | | FIVE YE | |
| ng physician and eas the buriel-transit | | disease or condition | e. ME | Due to (d | or es a conseq | uenca of): uenca of): | om of c | OLD W | | | FIVE YE | |
| ng physician and eas the buriel-transit | | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events | b | Due to (c | or es a consequence as | uenca of): uenca of): uenca of): | | 23b. Did t | | ntributs to | the cause of de | |
| ng physician and eas the buriel-transit | | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseasa or Injury that initiated events resulting in deeth) Lest | b | Due to (c Due to (c Dua to (c | or es a consequence as | uenca of): uenca of): uenca of): | | | | ntributs to | the cause of de | |
| ng physician and eas the buriel-transit | | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseasa or Injury that initiated events resulting in deeth) Lest | cd | Due to (c Due to (c Dua to (c | or es a consequence as | uenca of): uenca of): uenca of): | | 23b. Did t | | ntributs to 3 Probe | the cause of de | |
| ata has been signed by the attending physician and paga 2 should be detached for use as the buniel-transit Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseasa or Injury that initiated events resulting in deeth) Lest | cd | Due to (c Due to (c Dua to (c | or es a consequence as | uenca of): uenca of): uenca of): | | 23b. Did t | Yes 2 No | antribute to 3 Probe | the cause of de | |
| ata has been signed by the attending physician and paga 2 should be detached for use as the buniel-transit Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions. | d | Due to (c Due to (c Dua to (c | or es a consequence as | uenca of): uenca of): uenca of): derlying cause given | ven in Pert I. 26. Plece of Deal | 23b. Did t 1 1 1 24e. Wes perior | an eutopsy med? | antribute to 3 Probe | the cause of de ably 4 Unk re autopsy findir ilable prior to apletion of cause eeth? | |
| this certificate has been signed by the attending physician and elidirector, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions. 25. Wes case referred to medical exeminar? 1 Yes 25 No | d | Due to (c Due to (c) Dua to (c) eath but not res | or as a consequence as | uenca of): uenca of): uenca of): derlying cause given the second of t | ven in Pert I. 26. Plece of Deal | 23b. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | an eutopsy med? Yes 2 No ne) | ntributs to 3 Probe 24b. Wer avail component of do 1 I | the cause of de ably 4 Unk re autopsy findir liable prior to noletion of cause eath? | |
| this certificate has been signed by the attending physician and elidirector, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentielly ilst conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Pert II. Other significant conditions are summar? 1 Yes 2 No 27. Menner of Death Anturei 5 Pendia Investi | d | Due to (o Dua to (o Dua to to (o | or as a consequence as | uenca of): uenca of): uenca of): derlying cause given the second seco | ven in Pert I. 26. Plece of Deal | 23b. Did t 1 1 1 24e. Wes perfor | an eutopsy med? Yes 2 No ne) | ntributs to 3 Probe 24b. Wer avail component of do 1 I | the cause of de ably 4 Unk re autopsy findir liable prior to noletion of cause eath? | |
| this certificate has been signed by the attending physician and elidirector, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions are sexeminar? 1 Yes 25 No 27. Menner of Death | d | Due to (c Due to (c Due to (c) Due to (c) Part to (c) Due to (c) Due to (c) Due to (c) | or as a consequence of a co | uenca of): uenca | zen in Pert I. 26. Plece of Deal | 23b. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | an eutopsymed? Yes 2 No No ne) lence 6 □Oth low Injury occurr. | antributs to 3 Probe 24b. Wer avai com of de 1 □ | the cause of deably 4 Unk re autopsy findir liable prior to relation of cause eeth? Yes 2 No | |
| this certificate has been signed by the attending physician and elidirector, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions are exeminar? 1 | d | Due to (c Due to (c) Part of (c) Inpatient 2 (c) of Injury - At heng, etc. (Specification of my known) | or as a consequence of a co | uenca of): uenca of): uenca of): derlying cause given the time to the time | zen in Pert I. 26. Plece of Deal ner: 4□ Nursing Ho y et %? Yes 2□ No | 23b. Did t 1 1 Y 24e. Wes period 1 Y h (Check only or | an eutopsymed? Yes 2 No ne) Ience 6 Oth Now Injury occurr Street and Numb m, Stete) | 24b. Wer avail com of did. 1 red specify) red specify red pletion of cause eeth? Yes 2□ No Route Number, | |
| his certificate has been signed by the attending physician and all director, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner. | | disease or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest Pert II. Other significant conditions are summar? 1 Yes 2 No 27. Menner of Death 20 Neturei 5 Pendia Investia Suicida 6 Could determ 29a. Certifler (Check only 2 Medical) | d | Due to (c Due to (c) Due to | or as a consequence of a co | uenca of): uenca of): uenca of): uenca of): derlying cause given and the control of the cont | zen in Pert I. 26. Plece of Deal ner: 4□ Nursing Ho yet Yes 2□ No me, dete end pleca, pinion, deeth occur | 23b. Did t 1 1 Y 24e. Wes performed to the control of the contro | an eutopsymed? Yes 2 No ne) Ience 6 Oth Now Injury occurr Street and Numb m, Stete) | antribute to a savai com of de com o | the cause of deably 4 Unk re autopsy findir liabla prior to ripletion of cause eeth? Yes 2 No Roufe Number, eted. the cause(s) | |
| this certificate has been signed by the attending physician and elidirector, page 2 should be detached for use as the buniel-transit. To Be Completed by Physician/Medical Examiner | | disease or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions are summar? 1 | d | Due to (c Due to (c Due to (c Due to (c) Due to (c) Pue to (c) Due to (c) Due to (c) Pue to (c | or as a consequence of a consequence o | uenca of): uenca of): uenca of): uenca of): derlying cause given and the second and the seco | zen in Pert I. 26. Plece of Deal ier: 4□ Nursing Ho y et k? Yes 2□ No me, dete end pleca, pinion, deeth occur | 23b. Did t 1 1 Y 24e. Wes performent of the control of the contr | an eutopsymed? Yes 2 No ne) lence 6 Oth low injury occur Street and Numb m, Stete) ceuse(s) and me dete end pieca, (| antribute to a savai common of de common of | the cause of de ably 4 Unk re autopsy findir liable prior to role to r | |



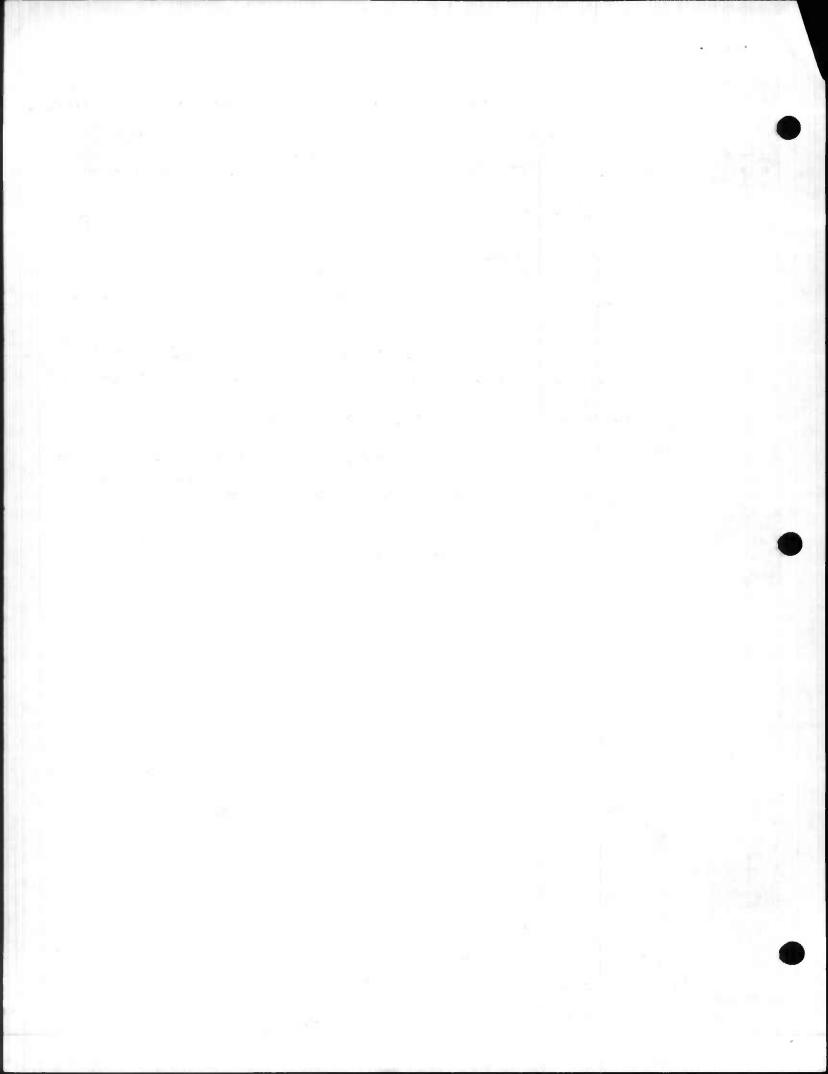
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 08^{Day} April **Physician** 1999" MARIE BRITTINGHAM 11:00 p.m NORMA /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge 602 Locust St. If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Date of Birth (Month, Day, July 2 Birthplece (State or Foreign Country)
 Maryland **Funeral** Months Days Hours 218-20-7522 71 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits t than "natural", or lierne 23s or 28s-f show the Medical Examiner must be notified at Dorchester Cambridge MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 U.S.A. 602 Locust St. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give' Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2/ No Specify. white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Impocrant. If frem 27 is marked other than any Injury or other transmind. Elementary/Secondary (0-12) College (1-4or 5+) clothing, retail sales clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Fleischman Marie Christian Reinholdt Scharpf Anna 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 764, Cambridge MD 21613 Mrs. Chris Wilke - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Duriai 2 Cremation 3 Removel from State Dorchester Memorial Park 4-12-99 Cambridge Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home, 21. Signature of Funeral Service Licensee 700 Locust St. Cambridge, MD 21613 UKK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final Pulmonery Disease disease or condition resulting in death) Examiner Examiner Asthma sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in death) Last Due to (or as a consequence of) that the death certificate be exec P.O. Box 68760, ed by the attending physician detached for use as the buna Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detacl 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findinga evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 200 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 🕰 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as steted. completely (Check only one) Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ53198 completed cause of deeth (Item 23a) (Type, Print) 1, Cambridge 503 Byrn ST Sutte 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

2 1999

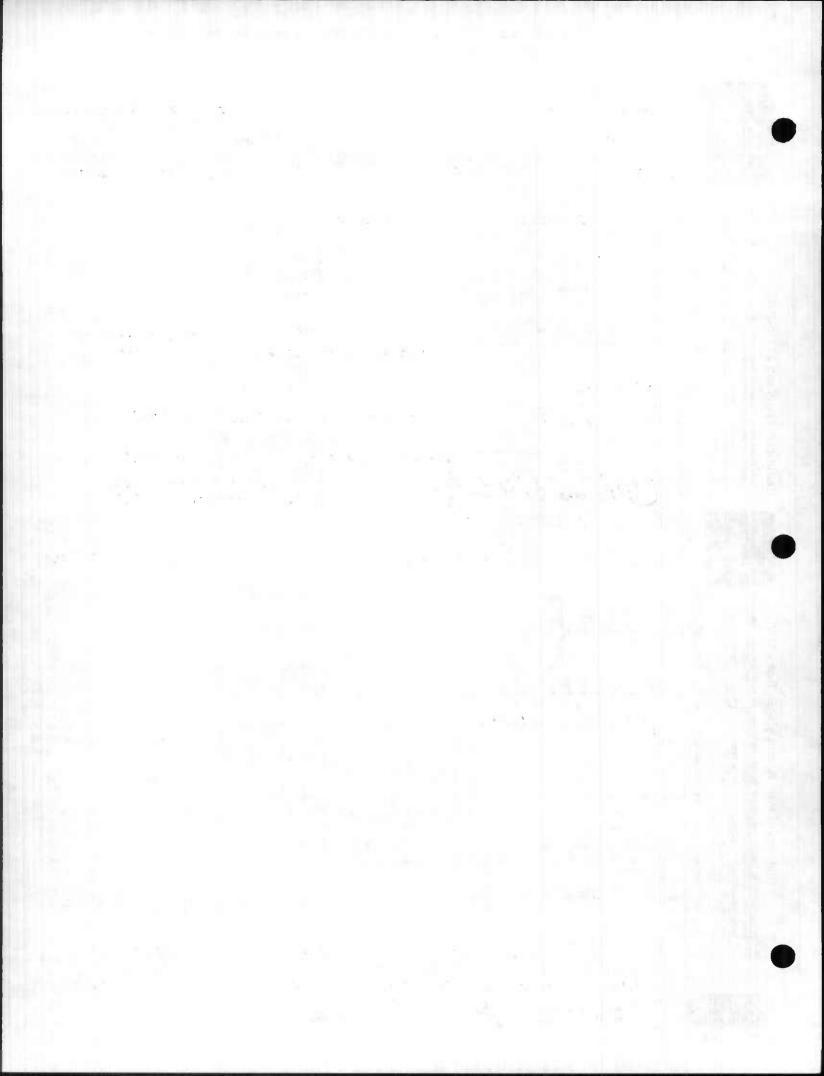


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 29 1999 5:45 am MARCH BERTINA COATES /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner ANNE ARUNDEL 1323 TYLER AVENUE ANNAPOLIS 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□ M 25€F Yrs. Director 213-22-1769 70 OCT. 28 1928 MARYLAND Usual Residance of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23e or 28e-f show traumade event, the Medical Examiner must be notified at 1 Yes 2 □ No ANNAPOLIS MARYLAND ANNE ARUNDEL Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1323 TYLER AVENUE 21403 US Funeral death 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiena. Important: If Itam 27 ie merked other than "naturel", or iter 1 ☐ Yas 2♥ No If Yes, Give Yaar or Dates: 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th ANNE ARUNDEL COUNTY 0 SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) ALBERT R. CARPENTER NANCY DORSEY 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 ROSECREST DR. ANNAPOLIS, MD. 21403 BETTY ANN WEEKLY (DAUGHTER) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) eny injury or ANNAPOLIS MEM. GARDENS 4/1/99 ANNAPOLIS, MD. 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licensee WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** 2 rot on titl /Medical immediate Cause (Final disaasa or condition resulting in death) (Ancar LIVER OF Examiner Due to (or as a consequence of): Examiner certificate be axecuted Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Disease or injury that initiated avants rasulting in daath) Last burial-tran Due to (or as a consequence of): and Box 68760. physician Physician/Medical the Dua to (or as a consequence of) 88 BSI ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the 3 Probably 4 Unknown 2 1 Yes 2 No signed l by 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of ceusa of daath? has certificate 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 □Othar (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 27. Mannar of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: Aftari or Attending 1 Natural 2 Accident 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No Investigation 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida Hospital of 24 hours a
 Funeral D edical 29a. Cartifier 🔁 Certifying Physician: To tha best of my knowledge, death occurred at the time, dete and plece, and dua to the ceusa(s) and manner as stated. completaly Medical Examiner: On the basis of axamination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the I 29d. Data signed (Month, Day, Year) certifiar 29b. Signature title 29c. Licansa number 029Y 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Dipopato Dr. chester ms 2,619 HECHANSEN 2108 32. Registrar's Signature ed (Month, Day, Year) State APR 0 5 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene Q Q | 3 | 0 |

| | | | | | Certificat | e of | Death | | R | eg. No. | | 0100 | | |
|---|---------------------------|---|---|-----------------|---|---------------------|---------------------------------------|---------------------------------|----------------------------------|------------------|-------------------------|--|--|--|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | | | 2. Date of Dee | | V | 3. Time of Deeth | | |
| Physicia | _ | Henry Russe | 11 Crum | | | | | | Month April | Day 2 | Year 1999 | 1:00AM | | |
| /Medic Examin | | 4e Fecility Neme (If not institution, giv | | | | | 4b. City, To | wn, or Lo | cation of Deeth | 4c. County | | 1.00111 | | |
| LAGIIIII | CI | 11201 Hill Rd. | | | | | Woo | dsbo | ro | F | reder | ick | | |
| Funeral | | Sociel Security Number 6. S | | yrs. last birt | hday) If Under Months | 1 Year | | 24 Hrs. Min. | 8. Date of Birth (Month, Day) | Vest | 9. Birthp | lace (Stete or Foreign try) | | |
| Director | | 213-01-9320 | ØM 2□F 8 | 8 | rs. | Days | Hours | IVIII). | Jan. 28. | 1911 | | ryland | | |
| 2 | | Usual Residence of Decedent | | | | | | | | | | | | |
| how | | 10a. State 10b. County | | c. City, Town | | | | | | | 10 | Od. Inside City Limits | | |
| e Ma | 용 | Maryland Frede | rick | | Woodsbo | oro | | | | | | 1 ☐ Yes 2 🕅 No | | |
| E 62 | Director | 10e. Street and Number | | | 10f. Zip | Code | | | 1 | 0g. Citizen of V | Vhat Coun | try? | | |
| 23a | | 11201 Hill Rd. | | | | | 21798 | | | U.S | | | | |
| r des | Funeral | 11. Meritel Status | 12. Wes Decedent Ever Armed Forces? | r in U,S. | 13. Was Dece | dent of cify Cul | Hispanic Or ban, Mexica | igin? (Spi n, Puerto | ecify Yes or No- Rican, etc.) | | e - Americ k, White, | | | |
| 20 afte | by F | 1 Never Married 2 Married | 1 Yes 2 No | | 1 ☐ Yes | 2 🖾 No | Specify: | | | Specify | White | | | |
| d 21215-0020 filed within 72 hours after death with the Maryland hygiene. wher then "natural", or frems 23a or 28a-f show ent, the Medical Evantine must be notified as | | 3 ☐ Widowed 4 ☐ Divorced | Year or Detes: | 1 40 | B | | 47 | | | | | | | |
| 15- n 72 n | Completed | 15. Decedent's En (Specify only highest gra | ducation ide completed) | 160. | Decedent's Usua (Give kind of wo life, DO NOT u | rk done | ipation o <i>during</i> mos adi | st of work | ina | oad con | | | | |
| within than | E | Elementery/Secondary (0-12) | College (1-4or 5+) | SIIT | erinten | | | | 1 | | eef | LCIOII/ | | |
| d 2 | e e | 17. Fether's Name (First, Middle, Last |) | Bol | er incen | uc | | 8. Mother's Neme (First, Middle | | | | | | |
| and be de | | Franklin Crum | | | | | | | sy Fox | | | | | |
| arylan should be and Mental marked or | 2 | 19a. Informent's Name/Reletionship (| 19h | Mailing Address | /Stree | - | | al Route Number | City or Town. | State. Zin | Code) | | | |
| Nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Manylan to it health and Mental Hygiene. If item 27 is marked other then "natural", or itema 23s or 28s4 show or other traumatic event, the Medical Examiner must be notified as | | Dorothy E. Crum/ | | | 201 Hill | | | | boro, MI | | | , | | |
| e, No 1 and Health Health where tr | - 1 | 20a. Method of Disposition | | 20b. Place of | Disposition (Nar | ne of | | | | 20c. Location - | City or To | wn, State | | |
| Pages nent of int: If the | - | 1 ■ Burial 2 □ Cremation 3 □ | | | y, crematory or o Hill Ce | | | 1 | /6/99 | nr. Woo | deho | ro MD | | |
| Baltimore, Mispermit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other treeplace. | - | 4 ☐ Donation 5 ☐ Other (Specifical Service Lican | | LA | | | | | | | | 10, 110 | | |
| Balti pemit. Departri importa any inju | | 21. Signature of Future 1 Service Citati | T) X/aJ | ler | 22. 1441110 41 | IU AUUI | 933 01 1 9011 | | zler Fu | | | | | |
| | | OCT / KOUNE | 0.7- | 2 | 404 S. | | | | loodsbor | | 1/98 | Annanimaka | | |
| | | 23a. Pert1. Enter the diseese, or com shock, or heart failure. List only | one ceuse on each line. | death. Do r | iot enter the mod | ie or cry | ing, such as | cerdiac | or respiratory an | est, | | Approximate tnterval Between Onset and Death | | |
| Physician /Medical | | immediate Cause (Final disease or condition resulting in death) e. Emply func | | | | | | | | | | | | |
| Examiner | | | | | | | | | | | | years | | |
| | - | | Dde | to (or as a | consequence of): | | | | | | | 0 | | |
| pe list | edicai Examiner | | | | | | | | | | | | | |
| Box 68760, eath certificate be executed attending physician and for use as the burial-transit | xar | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | |
| 68760, ificate be ex physician as the buria | ie | Cause (Disease of Injury C. | | | | | | | | | | | | |
| phys s the | 듛 | resulting in deeth) Lest | Due | to (or es e c | onsequence of): | | | | | | | | | |
| Box (Bath certification authoring for use a | 2 | | d | | | | | | | | | | | |
| cords, P.O. Box requires that the death ce been signed by the attendi should be detached for use | Be Completed by Physician | 2 - 1 2 - 1 - 1 - 1 | | | | | Landa Bad | | Ont Did to | | madbush a | the same of death? | | |
| tha do | nys | Pert II. Other significant conditions of | ontributing to death but he | ot resulting in | the underlying o | ause g | iven in Part | ι. | 1 17 | | | the cause of death? | | |
| that that detail | Y | prestalii | Cenus | | | | | | | 98 2421NO | 3 170 | Dabiy 4 Onknown | | |
| requiras | Q P | | | | | | | | 24e. Was e | n eutopsy | 24b. W | ere autopsy findings | | |
| Should be a | lete | | | | | | | | perfor | med? | CO | ailable prior to mpletion of cause death? | | |
| Rec e law | E | | | | | | | | 4.5 | •□!/ | + | | | |
| al B | ပို | 05.14 | | | | | | | 1 U Y | | 11. | ☐ Yes 2☐ No | | |
| of Vital Records, Physician: The law requires ti rthis certificate has been signe rrai director, page 2 should be | B | 25. Wes case referred to medicel examiner? | Hospital: | | | . 0 | ther | | h (Check only or | | 40. 1 | | | |
| M S 00 0 | 2 | 1 ☐ Yes 2/2/No 27. Manner of Deeth | 1 ☐ Inpatient 28a. Dete of Injury | | tpatient 3□ Do | JA | 4 L N | ursing Ho | ome 5 Resid | | | y) | | |
| On ding i | lo lo | 1 ☑Netural 5 ☐ Pending | (Month, Day Ye | | njury | 28c. Inj W | ork? ⊒Yes 2□ | 1No | Eco. Docomoc II | on injury occur | | | | |
| Vision Attending Attending Attending Attending Attention | icat | 2 Accident investigatio 3 Suicide 6 Could not b | | At home fo | | | | 1110 | 28f Location /S | treat and Numl | her or Run | al Route Number, | | |
| Division i or Attending after death. Director: After d in by the fune | Certification: | 4 Homicide determined | 28e. Place of Injury building, etc. (5 | Specify) | im, street, factor | y, onice | | | City or Tow | | 707 07 71070 | | | |
| Division of the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this complataly filled in by the funeral | | 29a. Certifier 1 Certifying Ph | ysician: To the best of m | u knowlodeo | dooth occurred | at the | time date a | nd place | and due to the o | auce/s) and m | anner ac c | teted | | |
| To the Hospital within 24 hours To the Funeral complataly filled | edicai | (Check only 2 Medical Examone) | niner: On the best of manner: On the bests of exe | eminetion en | dor investigation | , in my | opinion, de | eth occur | red at the time, o | late end piece, | and due to | the ceuse(s) | | |
| To the He within 24 To the Fu | M | 29b. Signature and tille of certifier f | , / | | 29 | c. Licer | nse number | | - 1 | 29d. Date signe | d (Month, | Day, Year) | | |
| F 3 F 8 | | N/A | Wilalia | | | 1 | 122 | 11.1 | | HI | 166 | | | |
| | - | 30 Name and addressed assess | nul V V | /Itam 2251 / | Type Drint | 1/ | 11 | 101 | | 1/1/ | -/7 | | | |
| | | 30. Name and address/of person who | A (FC) \ > ^ | (nem 238) (| Type, Print) | 1 | 2111 | al | 1 5 | 11. | 1 11 | 12171 | | |
| Sta | te | 31. Dete filed (Month, Day, Year) | 32, Registrar's | Signature | 17/11 | , T | | | IN | - Cu | / Vn | , , , , , , , | | |
| Registra | | | 99 Bener | 1 | 19. A | rou | 6 | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month Vear **Physician** Robert Charles Condry 1999 April 12:21PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Prince George's 6. Sex 1 ☒ M 2 ☐ F If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Director 266-20-8424 Florida Usual Residence of Decedent 10a. Stata 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f show 1 No 2 No Director Mitchellville Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Norms 23a United States 20721 Funeral 11500 Tomme Court 12. Was Decedent Evar in U,S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Year or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Black. Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Wholesaler Self-employed permit. Pages 1 and 2 should be liked Department of Health and Mental Hygie Important: If Isan 27 is marked other I any injury or other traumatic event. Its 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) D.C. 2515 R St., S.E. #6; Wash., Kevin Chatman -Grandson 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 4/9/99 Clinton, MD 22. Nama and Address of Facility 21. Signature of Funaral Sarvice License Stewart Funeral Home was 4001 Benning Rd., N.E. Wash., D.C. 20019 the tha disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting In daath) /Medical Examiner Examiner umonia physician and s the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): or Attending Physician: The law requires that the death certificate for use Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0 Concer disea 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 No 25. Was case rafarred to medical examinar? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mennes of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Netural 5 Pending To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: Aft completely filled in by tha fun 1 Yas 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 29a. Cartifier 1 Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) D19609. Tal, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMAN R. TULI. 3503 PERRY STREET, MOUNT RAINIER. MD 20712. APR 0 8 1999 32 Registrar's Signatura State Registrar

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Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) PAULETTE COLEMAN 9-30 A.M 04 08 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AUREL REGIONAL HOSPITAL PRINCE GEORGES LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 1□M 2 F 579-70-7453 29 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10e State 10b. County 10c City Town or Location 1- Yes 2 □ No Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Dodge Park Road, # 103 20785 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Administrative Clerk 2 yrs Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Smith Rose Wilkerson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3320 Dodge park Road, #103, Landover, Maryland 20785 Rosie L. Coleman/Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/15 1 Bunal 2 ☐ Cremation 3 ☐ Removel from \$4 Forrest Hills Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 1999 21. Signature of Funeral 9 22. Neme and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death EXTENSIVE LEFT HEMISPHERE Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in deeth) PERTENSION Due to (or es e consequenca of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last TYPER CHOLESTEREMIA, ARTERIOSCEEROSIS Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy CORONARY ARTERY DISEASE and completion of cause of death? Coronaling balls - Silvagery 1 Yes 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Department of Important: If any injury or

Physician

/Medical

Examiner

Directo

Funeral

P

Director

7 is marked other than "natural", or itams 23a or traumatic evant, the Medical Examiner must be a

Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. nt: If item 27 is marked other than "I iry or other traumatic evant, the Mes.

Baltimore,

the Maryla

physician and s the burial-trans use ed by t signed t

Examiner

Physician/Medical

Aq

Completed

P.

Certification:

page 2 cartificata 24 hours a

P.O. Box 68760. Division of Vital Records, Attanding after death. Diractor: Aft 8 Hospital

edical To the Hosp within 24 ho To the Fune completely f

Registrar

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Donpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number 29d. Date signed (Month, Day, Year) 21294

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL NAYEEM, MID . 3450- FORT MEADE ROAD SUITEIOU LAUREL

31. Date filed (Month, Day, Year) APR 0 9 1999

29b. Signature and title of certified



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) 403 APRIL 1999 Gracie LaVerne Cash 4a Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deat GEORGES GEORGES CENTER CHEVERLY HOSPITAL PRINCE **YRINGS** If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1 M 20 F 223-58-5507 48 June 26, 1950 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Prince Georges Seat Pleasant 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 618 Birch Leaf Avenue 20743 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yaar or Datas: 14. Rece - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Bleck, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Buainass/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 yrs Accountant Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Raymond White Mary Virginia Thompson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Phala Grant/Daughter 207 Clay Street, Suffolk, Virginia 23434 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 04/12 1 ☐ Burial 2 ☐ Cremetion 3 ♣ Removel from State Carver Memorial Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Suffolk, Virginia 22. Nama and Addrass of Fecility 21. Signeture of Funerel Service Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 lecen 23a. Pert1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heaft failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel . HYPERTENSIVE ARTEROSCLEPOTIC CARDIOVASCULAR PISEASE diseese or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) 2 ER/Outpetient 3□ DOA 1 Inpatient

Physician /Medicai **Examiner**

Physician

/Medical

Examiner

Directo

Funeral

p

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Modical Expansion mast be notified as

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important; if tem 27 is marked other than any injury or other traumatic avant

the Marylend

With

death

72 hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be 2

physicien end the burial-tran 68 USB page 2 director, uneral Certification:

certificate be exec Box 68760, signed by the a Records, peed certificate Division of Vital Attending Physician: this Affer

Hospital or Attending 24 hours after death. Funeral Director: Ath To the

State Registrar

Medical

29b. Signati

MARIO

25. Wes case referred to medicel examiner? Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 ☐ Accident 5 Pending 1 Yes 2 No Invastigetion 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es ateted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) 29a. Certifier

29c. License number

29d. Dete algned (Month, Day, Year)

ause of deeth TK GOLVE 31. Dete filed (Month, Dey, Year) APR 0 9 1999

HOSPITAL DRIVE, CHEVERLY, MARYLAND 3001 32 Registrer's Signeture

(Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

| | | | C | ertificate of | Death | | eg. No. | 9 13104 | | | | | |
|--|--|---|--|---|--|---|-----------------------------------|---|--|--|--|--|--|
| Physician | Decedent's Neme (First, Middle, La | | | | | 2. Dete of Dee Month | Dey | 3. Time of Death | | | | | |
| /Medical | Joseph W. Car | April | 4 1 | .999 5:30PM | | | | | | | | | |
| Examiner | 4e Fecility Neme (If not Institution, give | re street end number) G1a | adys S | pellman | 4b. City, Town, or Lo | ocation of Deeth | 4c. County | of Deeth | | | | | |
| | Specialty Hos | pital and Nurs | sing C | enter | Cheverly | 7 | Prin | ce George's | | | | | |
| Funeral Director | | Sex 7. Age (In yrs | | Months Dave | | 8. Dete of Birth Month, Day Aug . 2 | 7°°1923 | 9. Birthplece (State or Foreign Country) Wash., D.C. | | | | | |
| 72 hours efter deeth with the Meryland natural", or thams 23s or 28s-4 show sites Examiner must be notified at steed by Funeral Director | Usuel Residence of Decedent | | | | | | | T | | | | | |
| | 10e. Stete 10b. County | | ity, Town or | | | | | 10d. Inside City Limits | | | | | |
| cto de cto | Maryland Prince | George's | | Cheverly | | | | 1 □Yes 2 □ No | | | | | |
| or items 23s or 28s-1 show mayner or items 23s or 28s-1 show immer must be notified at 7 Funeral Director | 10e. Street end Number 2900 Mercy Lan | e | | 10f. Zip Code | 20785 | 1 | Og. Citizen of V Unite | vhot Country? d States | | | | | |
| r Heme 23s | 11. Maritel Stafus | 12. Wes Decedent Ever in Armed Forces? | U,S. 1 | 3. Was Decedent of | Hispanic Origin? (Spon, Mexican, Puerto | ecify Yes or No- | 14. Race | e - American Indien, k, White, etc. | | | | | |
| ar, or he | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Yeer or Detes: | | 1 ☐ Yes 2 ☐ No | | ricari, etc.) | Specify | | | | | | |
| natural", scient Exe | 15. Decedent's E | ducation | 16e. De | cedent's Usuel Occu | pation | | 18b. Kind of Bu | siness/industry | | | | | |
| | (Specify only highest gri | College (1-4or 5+) | - (Gi | ive kind of work done o. DO NOT use retire | pation during most of work ed) | ing | | | | | | | |
| than the M | Elementary/Secondary (0-12) | Conogo (1 401 01) | | Pr | inter | | Gove | rnment | | | | | |
| arked other atic event, I | 17. Fether's Neme (First, Middle, Last James W. | Carrington | | | | ne (First, Middle, Maiden Sumeme) Nicy Edmunds | | | | | | | |
| Tarri Tarri | 19e. Informent's Neme/Reletionship (| Type, Print) | 19b. Me | eiling Address (Stree | t end Number or Run | el Route Numbe | r, City or Town, | Stete, Zip Code) | | | | | |
| 27 Is | Moretha C. Lanca | | . 1 | 717 Lyman | Pl., N.E. | Wash | D.C. 2 | 0002 | | | | | |
| item 2 | 20e. Method of Disposition | | Plece of Dis | sposition (Neme of | | | | City or Town, Stete | | | | | |
| = 5 | 1 △ Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specia | | | co Nation | | 1/12/99 | 9 Triangle, VA | | | | | | |
| Important: any injury | 21. Signiture of Funeral Service Licensee 22. Name end Address of Fecility Stewart Funeral Home | | | | | | | | | | | | |
| 5 6 0 | 23e. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 4001 Benning Rd., N.E. Wash., D.C. 20019 Approximate interval Between | | | | | | | | | | | | |
| ed by the ettending physician end detached for use as the buriel-frensit auripan land in the physician/Medical Examiner | Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | e | (or es e condition of a se con | sequence of): | Hears | | | Approximate interval Between Onset and Deeth Mans C | | | | | |
| the elf | Pert II. Other significant conditions of | contributing to death but not re | sulting In the | e underlying cause g | iven in Pert I. | 23b. Did to | obacco use cor | ntribute to the cause of death? | | | | | |
| d by detac | | | | | | 1 🗆 Y | 'es 2□ No | 3 Probably 4 Unknown | | | | | |
| 53 5 | | | | | | - 40000 | | Oth Man automatications | | | | | |
| page 2 should Completed | | | | | | 24a. Wes e perfor | | 24b. Were autopsy findings evelleble prior to completion of cause | | | | | |
| 0 C/ LL | | 11-13 | | | | | | of death? | | | | | |
| Pag | | | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2 ☐ No | | | | | |
| Be Be | 25. Wes case referred to medical exeminer? | | | | 28. Plece of Deet | h (Check only or | ne) | | | | | | |
| this call dire | 1 Yes 2 Ne | Hospitel: 1 ☐ Inpatient 2 | ☐ ER/Outpat | tient 3□ DOA O | her: 4 Nursing Ho | me 5 Resid | ence 8 Oth | er (Specify) | | | | | |
| ter then the | 27. Menner of Deeth 1 Neturel 5 Pending | 28e. Date of Injury (Month, Dey Year) | 28b. Time Injur | | iry et ork? | 28d. Describe h | ow injury occur | red | | | | | |
| r: Ar | 2 Accident Investigatio | n | | | Yes 2 No | | | | | | | | |
| ed in by the funeral ed in by the funeral Certification: | 3 Suicide 8 Could not be determined | 28e. Placa of Injury - At building, etc. (Spec | home, ferm, ify) | street, facfory, offica | | 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) | | | | | | | |
| Funer etely fill dical | 29e. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1 | nysician: To the best of my on miner: On the basis of examin and menner stafed. | owledge, de etion end/or | eth occurred et the t investigation, in my | ime, date end plece, opinion, deeth occur | end due to the c red et the time, d | ause(s) end me late end placa, | onner as stated. end due to the cause(s) | | | | | |
| Me | 29b. Signature and title of contifier | N.C | | 29c. Licen | se number | 2 , | 29d. Dete signe | d (Month, Dey, Year) | | | | | |
| 11) | Les | M). |) | 1) | 117/ | 0 9 | カー | 97 | | | | | |
| D- | 30. Names and address of person who | A 1/11/- | om 23e) (T/) | De, Print) | che | verl | /M. | 20785 | | | | | |
| State | 31. Dete filed (Month, Dey, Yeer) | 32, Registrer's Sign | neture | | | / | | | | | | | |
| Registrar | APR 0 7 1999 | Sheva | 1 | Spark | | | | | | | | | |
| 16 Bey 6/95 | | - | | POPULOR | | | | | | | | | |

1881 TO 1881

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APR 1051 AM **Physician** HAROLD CLINISCALE /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1-10 M 2□ F Months 290-32-3019 Director December 25, 1937 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yas 2 □ No Directo 288-7 Maryland Prince Georges Ft. Washington ğ 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b Berns 23a 8412 Driftwood Lane 20744 U.S.A. 14. Race - American Indian, Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: by **Black** 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) 5+ Elementery/Secondery (0-12) Pharmacist Private 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nant of Health and Mental Benjamin Wilson Lovey Robinson 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 is any Injury or other tra 8412 Driftwood Lane, Ft. Washington, Maryland 20744 Patricia Clinkscale/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 04/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 1999 Clinton, Maryland 22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Sarvice Licensee Ken 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 cen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseesa or condition resulting in death) Examiner Examiner COM DIOURSCULAN WERIOSELENDA physician and the burial-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initioled events resulting in death) Last Due to (or as a consequence of) Box 68760 edicai Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown by Records, Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was casa referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this 27. Menner of Death 28b. Tima ol 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 Netural death. 1 TYes 2 No 2 Accident after deat 3 Suicide 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide

To the Hospital within 24 hours or To the Funeral I completely filled

hours a Hospital

> W1507564 31. Date filed (Month, Day, Year) State APR 0 7 1999 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 610 32. Registrar's Signatura

OUN

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. License number

LINE CENTER

29d. Date signed (Month, Day, Year)

WALDONE Md. ZOGOZ

261 L G 2 1880

The very

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5,1999 MATTIE APRIL 7:06pm COLLINS /Medical 4a Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. lest birthday) 84 Yrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1 M 2 K) F Director July 17,1914 577-66-5955 South Carolina with the Marylend 10a. State 10c. City. Town or Location 10b. County 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. P.G. Forestville Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 6006 Parkland Court #301 U,S,A, Funeral death 12. Was Decedent Ever in U,S. Armed Forces v 1 ☐ Yes 21 ☐ No tf Yes, Giva Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritai Status Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐No Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) permit. Peges 1 and 2 should be filed within Department of Health end Mental Hygiena. Important: If Itam 27 is merked other than any injury or other traumatic average. Elamantary/Secondary (0-12) Coilege (1-4or 5+) Housewife Private 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be Andrew McKelvin Rebecca Williams 19b. Mailing Address (Streat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 6006 Parkland Court #301, Forestville Md. 20747 Jimmy Collins/Son 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Burlai 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 4/10/99 Harmony Memorial Park Landover, Md. 22. Name and Address of Facility Johnson & Jenkins Inc. at Funeral Service Lice 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata tntarval Between Onset and Death **Physician** /Medical immediata Causa (Final Athero Schuetce disease or condition rasulting in daath) Examiner Due to (or as a consequenca of): Examiner physician and s the buriel-transit the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequanca of): Physician/Medical Due to (or as a consequence of) 98 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CANCER à 24b. Wera autopsy findings svallable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? peen page 2 : has 1 Yes 2 No 1 Yes 2 No certificate or Attending Physicien: after death. Director: After this certifica Be 25. Was case referred to medical 26. Piaca of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of Certification: 1 Naturai 5 Panding invastigation Injury 1 Yes 2 No 2 Accident To the Hospital or Atte within 24 hours after da: To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide edicai 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and placa, and dua to the causa(s) and manner as stated.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

State Registrar

HOSPITAL 31. Date filed (Month, Dey, Year) APR 0 7 1999

29b. Signatura and titla of cartifiar

29a, Certifier



rson who completed causa of death (item 23a) (Type, Print)

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated.

29c. Licansa number

29d. Date signed (Month, Dey, Year)

9881 TO 1814

| AMENDED | 170 | M #5 050 5U 0770 6/0/00 | State of Marylar | | rtment <i>tificate</i> | | | nd M | | | 1 | 3.1 | 0.7 |
|--|----------------|---|---|------------------------|---------------------------|----------------|-------------------|------------|----------------------------------|------------------|-----------------|------------------------|----------------------|
| AMENUEU | 116 | M #5 PER FH G772 6/2/99 1. Decedent's Neme (First, Middle, Last) | | 001 | imouto | OI L | Journ | | 2. Dete of Deet | eg. No. | | 3. Time | e of Death |
| Physic | | Esther Wi | II Anna Sco | . + + C - | | | | | Month | Dey 2. 19 | Yeer | | 05 PM |
| /Med Exam | | 4e. Fecility Neme (If not institution, give : | | ill Ca | rter | 4t | o. City, Tov | vn, or Loc | April cation of Deeth | 4c. County | 9 9 of Deeth | 4: | US PIN |
| | | 806 Festival Cou | rt | | | 1 | Mitcl | h e 1 1 | ville | Prin | ce G | eor | qe's |
| Funera | | Sociel Security Number 6. Sex | | | If Under 1 | | If Under 2 | | 8. Dete of Birth (Month, Day, | | | | te or Foreign |
| Director | | 253 03 4319 | M 2 KF 85 | Yrs. | Wichitis | Duys | riours | IVIII I. | Sep 23 | 3,1913 | Jack | SOI | Miss |
| pue » | | Usual Residence of Decedent 10e. Stete 10b. County | 10c. Ci | ty, Town or Loc | cation | | | | | | 10 | d Inside | City Limits |
| Menylen f show | 5 | Md Prince (| | Mitch | | 11 | l e | | | | es 2 No | | |
| h the Meryler r 28a-1 show | Director | 10e. Street end Number | 3 | | 10f, Zip C | | | | 11 | Og. Citizen of \ | Whet Count | rv? | |
| th with | | 806 Festival | Court | | 2 | 2072 | 2 1 | | | USA | | | |
| 5-0020 72 hours efter death with the Meryland natural, or litems 23s or 28s-1 show area Examiner mant be nettined at | Funerai | 11. Maritel Status | 2. Was Decedent Ever In U | J,S. 13. V | Vas Decede | nt of His | spenic Orig | in? (Spe | cify Yes or No- Rican, etc.) | | e - America | | , |
| or he | F | 1 Never Merried 2 Merried | Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give | | Yes, specif | | | Puerto | rican, etc.) | | ck, White, e | | |
| ours raf, | d by | 3 🕅 XVidowed 4 □ Divorced | Yeer or Dates: | | L 105 2) | (1) Mo | Specify: | | | Specify | /: B1 | ack | |
| | Completed | 15. Decedent's Educ (Specify only highest grade | eation completed) | 16a. Deced (Give I | kind of work | done di | urina most | of working | ng en | 16b. Kind of Bi | usiness/Ind | ustry | |
| d 2121 filled within Hygiene. ther than | ф | Elementery/Secondery (0-12) | College (1-4or 5+) | | <i>rnali</i> | | | | | newsp | 2000 | | |
| and 2 lbe filed hall Hygid of other | ပို | 17. Fether's Neme (First, Middle, Last) | ' | 300 | | - | 18. Mother | 's Neme | (First, Middle, N | | ' | | |
| yian ouid be Mental Mental | To Be | William A. Sco | | . Sout | | | | | | | | | |
| re, Maryiand 2 s 1 and 2 should be filled f Health and Mental Hygi tem 27 is marked other other traumatic event, t | - | 19a. Informent's Name/Relationship (Typ | pe, Print) | 19b. Mailin | g Address (| Street e | nd Number | r or Rura | Route Number, | City or Town, | State, Zip | Code) | |
| Mand 2 alth a selth a ser tra | | Esther S. Carte | r daughter | | W . | | | | | yton, | | | 9 |
| Baitimore, M permit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra | | 20e. Method of Disposition | 1 | Piece of Dispos | sition (Name | of er plece |) | | Dete 2 | 20c. Location - | City or Tov | vn, Stete | |
| | | 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify) | emover from Stete | antic | · . | | , | 4 | /7/99 | Tria | n g 1 e | , V | A |
| | | 21. Signeture of Funerel Service License | 9 | 22. | Neme end | Address | of Fecility | Gr | eene | unera | 1 Ho | me | Inc |
| | | Valson, E) | Lean V | 8 | 14 Fr | anl | clin | St | Alexa | ndria | VA | 223 | 1 4 |
| | | 23a. Pert1. Enter the disease, or complications, or heart feilure. List only on | cetions that caused the deat | th. Do not ente | er the mode | of dying | , such es c | cardiec or | respiretory arre | est, | 1 | Approxir Interval I | nete |
| Physician | | | | | | | | | | | 1 | Onset si | nd Death |
| /Medical Examiner | | Immediate Ceuse (Fine) disease or condition | Cardia | 1701 D | ina | Lov | 11 1 | 201 | rest | | 2 | nn | niin |
| Examine | | resulting In deeth) | Due to (c | or es e consequ | uence of): | (| 9,0 | U | | | | 2-1-3 | -000 |
| P # | Examiner | _ b | MUMICY | ans | 2 - | fa | ell | u | L | | | | |
| 8760, ete be executed hysicien end the burtal-transit | xar | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due to (d | or e consequ | uence of): | | , | , | | | | | |
| 8760, ete be ex hysicien the burial | cai | Cause (Diseese or Injury thet initieted events | adres | al | all | m | d | tu | mo | | <u> </u> | | |
| 68 ifficet g phy | | resulting in deeth) Lest | Due to (o | r es e consequ | lende of): | | | | | | 1 | | |
| Box 6 Beth certific ettending p | 2 | · d | | | | | | | | | | | |
| i Records, P.O. Box 68 The lew requires that the deeth certificate has been signed by the ettending plage 2 should be deteched for use as t | Physician/Mec | Part II. Other significant conditions conf | ributing to death but not res | ulting in the un | derlying cau | se giver | n in Pert i. | | 23b. Did to | bacco use co | ntribute to | the caus | e of death? |
| s that the de gened by the be deteched | , h | | | | , | | | | 1 🗆 Ye | 2000 | 3 Prob | ably 4 | Unknown |
| ds, Fuires that signed de ded | by | Cere provasa | ular ac | ad | eni | | | | | ~ | | | |
| Cord | pet | Sumples | 21 | | | | | | 24e. Wes en | autopsy ned? | ave | lable pri | sy findings or to |
| Records, he lew requires the lew sequences the bean signed age 2 should be considered. | Completed | nempless | | | | | | | | | of d | pletion (eath? | f cause |
| ate h age | 00 | Schmonh. | renin | | | | | | 1 ☐ Ye | 8 2 XNO | 10 | Yes 2 | P No |
| Vitai Fidelen: The certificate | Be | 25. Wes case referred to medical exeminer? | | | | | | of Deeth | (Check only on | e) | | | |
| Of O Physic this c | 70 | 10 162 50 140 | ospitei: 1 Inpatient 2 | | | | 4 1401 | | ne Reside | | |) | |
| After funer | lon | 27. Manner of Deeth 1 Deletural 5 Pending | 28a, Dete of injury (Month, Day Year) | 28b. Time of Injury | M 280 | Work | et ? es 2⊡N | 1 | 8d. Describe ho | w Injury occur | red | | |
| Division of Vitai or or Attending Physicien: The effor death. Director: Affer this certificate in by the funeral director, parts. | Certification: | 2 Accident investigation 3 Sulcide 6 Could not be | 28e. Piece of Injury - At he | ome ferm stre | | | 69 2014 | _ | 8f. Location (Str | reet and Numb | er or Rural | Route N | umher |
| Div A | E. | 4 Homicide determined | building, etc. (Specif | y) | ot, rectory, t | Jillob | | | City or Town | , Stete) | 01 01 11010 | 71001074 | arribor, |
| Division of Vitai Record To the Hospital or Attending Physician: The lew requir within 24 hours effer death. To the Funeral Director: Affer this certificate has been si completely filled in by the funeral director, page 2 should | | 29a. Certifier Certifying Physical Examin | cian: To the best of my kno | wledge, deeth | occurred et | the time | , dete end | place, a | nd due to the ca | use(s) end ma | nner as sta | ited. | |
| the H tin 24 the F | Medicai | one) | end manner steted. | tion end/or inve | | | | 1 occurre | | | | | |
| T Vill | - | 29b. Signature end title of certifier | 000- | | 29c. l | icense | number | | 29 | d. Dete signe | d (Month, D | ay, Yea |) |
| (5) | | Luphennia | 100 | mo | 5 | 04 | 183 | 65 | | 4/ 5 | 5/6 | 19 | , |
| 112/ | | EUPHEMIA BRUMSI | TINE-OTANG" | MD (Type, F | rint) 121 | 72 | Cen | tra | e Avis | # 100 | - | | |
| Sta | te | 31. Dete filed (Month, Day, Year) | 32. Registrer's Signe | eture . | wa | el | levi | lle | me | 1 2 | 070 | _ | |
| Regist | | APR 0 6 1999 | nema | 4 | - | ¥ | | | | | | | |

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are general graph to a contract the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Y Day **Physician** 0345 31000 1999 PY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montpomery Spring Moly SILVEY Cro 99 Nos 0 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M XXF Yrs. Director 244-48-9910 67 Greenville, NC the Maryland 10a State 10c City Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylen nant of Health and Mental thyglene.
Instit if them 27 is marked other than "natural", or theme 23a or 28e-1 show my or other traumatic event, the lead 1 Yes 2 □ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910- RoseMary Hill Drive #3 20910 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2K No Specify: à 3 00 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a 8th Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Ardell Taylor Mary Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Mae Richardson/Daughter 1910- RoseMary Hill Dr. #3 Silver Spring, Md. 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or of 1 Burial 2 Cremation 3 Removal from State Riverdale Park Crematory 4/7/99 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature of Funeral Service Licenses 814- Upshur Street, N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Exganquina Examiner Physician/Medical Examiner do MOYA physician and the buriel-transit The law requires that the death certificate be assecuted Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. a Due to (or as a consequence of) resulting in de USO as t 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physicien: 25. Was case referred to medical exagniner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Inpetient this funeral 27 Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation s effer des. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3€ Suicide 4 ☐ Homicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 Medical Examiner: On the basis of examination and/or investination, in my opinion, death accounted at the cause(s) and manner as stated. Hospital 24 hours Medical completely niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 100

State Registrar 31. Date filed (Month, Day, Year) APR 0 5 1999

medica

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30. Name and address of person who com

29b. Signature and title of certified

Pars 35 Registrar's Signature

MIDME

d_cause of death (Item 23a) (Type, Print)

29c. License number

IRA

0042

29d. Date signed (Month, Day, Year)

mo

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** 4b. City, Town, or Location of Death RTHUR homas : OOAM /Medicai 4c County of Death 4a. Facility Name (If not Institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Data of Bir Months Days Hours Min. (Month, Da ace evon Dorchester Security Number 1-28-878 6. Sex 100 M 2 D F 7. Age (In yrs. last birthday) 2 Yrs. Funeral July 06, 1916 Makyland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumetic event, the Medical Examinar must be notified at 1 Tes 2 No Director Dorchester ambrid 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ace Funeral d 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify: þ Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiens. Department of Health and Martal Hygeria. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementery/Secondary (0-12) College (1-4or 5+) hauf CUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Isaac 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Beral Route Number, City or Town, State, Zip Code) Thomas Copper 1/- Ut V Cr. 2016. Place of Disposition (Name of camefery, crematory or other place) Place Dete 200. Location - City or Town, State 20a. Method of Disposition 110/99 1 Burial 2 Cremetion 3 Removal from State aradise Cemetery TRappe, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY Funeral 23a. Pert.) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiration, or heart failure. List only one cause on each line. Cambridge, MD, 21613 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Zheimes end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): stroke Physician/Medical the Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Mellitus signed t ρ Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? Cancer rostate this certificate 1 ☐ Yes > No 1 ☐ Yes 🕍 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 PNC 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Medical Certification: 5 Pending investigation Naturel 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. P.O. Records. Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Saltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

503

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

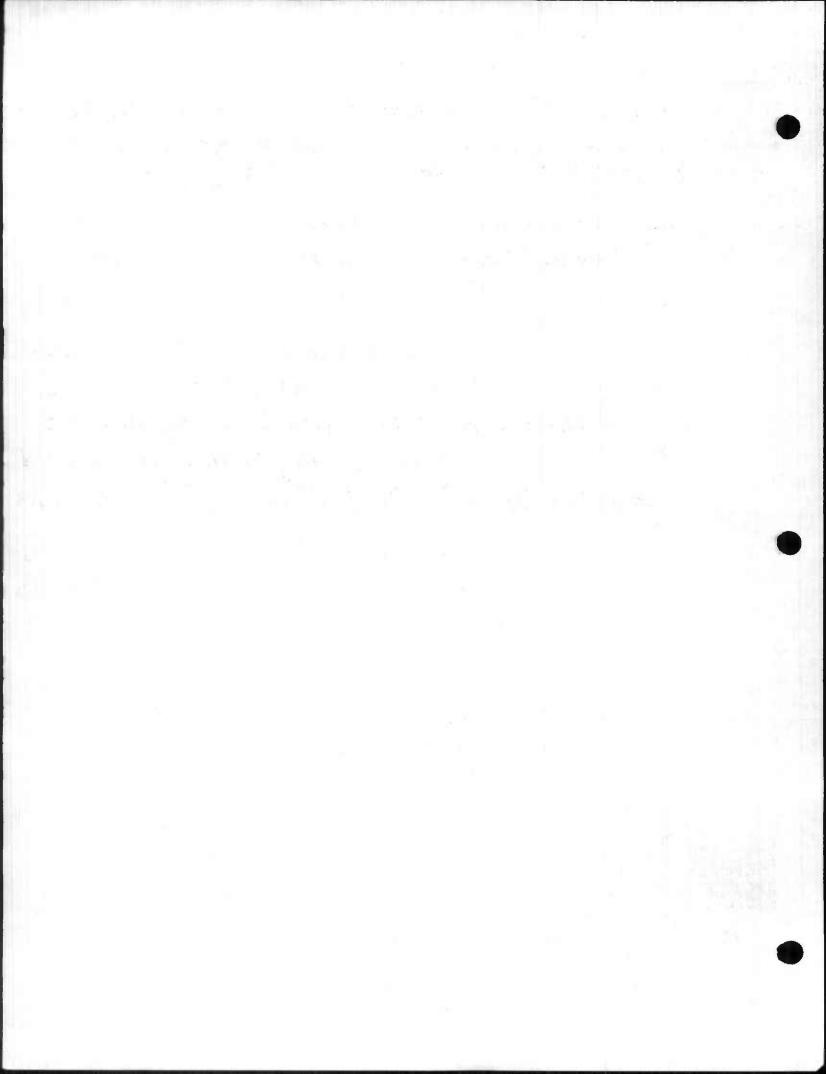
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

29c. License number

Cambridge,

29d. Dete signed (Month, Day, Year)

DHMH 16 Rev 6/95



| repartment of riealth and Mental | rrygiene | |
|----------------------------------|----------|----|
| Certificate of Death | Don No. | 00 |

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Day **Physician** Quentin M. Davidson, Jr. APRIL 5, 1999 9:01 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES 3406 CURTIS DRIVE OXON HILL 8. Date of Birth (Month, Day, Year) Feb. 15, 1983 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days 1⋤M 2□ F Hours 578-08-4250 16 Yrs. Washington, D. C Director Usual Residence of Decedent deeth with the Meryland 10b. County 10c. City, Town or Location 10a, Stata 10d. Inside City Limits ehow mast be notified at 1 FYes 2 No Maryland Prince George's Directo Hillcrest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Curtis Dr. #203 20746 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Reme : 11. Meritel Status filed within 72 hours efter Hygiene. other then *neturel*, or he 1 Never Married 2 ☐ Married 21215-0020 ò 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student School. permit. Pages 1 and 2 should be filed v. Department of Health and Mental thygiel important: if item 27 is marked other the eny injury or other traumatic event, the page. 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) 8 Quentin M. Davidson, Sr. Chevella Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Chevella Harris/ Mother 3404 Curtis Dr. #203 Hillcrest Heights, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 15 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 4/10/99 Clinton, Md. 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licens 5538 Marlboro Pike/Forestville, Md. 20747 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner The lew requires that the death certificate be assected burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physicien s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): US0 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, should be d à 24b. Wara autopsy findings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes certificate of Vital or Attending Physician: funeral director. 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence X Other (Specify) AT SCENE Certification: To XXYes 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Natural 5 Pending Subject Slot 1 Yes 2 No 4/5/99 investigation 2 Accident 2030 4 M To the Hospital C. Within 24 hours after deet To the Funeral Director 281. Location (Street and Number or Flural Floute Number. City or Town, State) 3 606 Curtis Mrive UX n Hill Muyland 6 Could not be 3 D Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the tima, deta and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier ck only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E APRIL 6, 1999

State Registrar

Day, Yes 9 1999

/ HEUDOREMIKE

32. Registrar's Signature

30. Name and addrass of person who completed cases of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Marie D. Spark

656 1 1 40 M

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1999 4:00 PM 1, COSTANTINO DeLEONEBUS APRIL 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 10 M 2 F Months Hours 81 579-22-4251 JULY 2, 1917 WASHINGTON, D.C. Usuai Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1X Yes 2 No PRINCE GEORGES MARYLAND BRENTWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 4413 34TH STREET 20722 12. Was Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 N Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) AUTO MECHANIC AUTOMOTIVE 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DeLEONEBUS CARMELLA BOCCABELLO GIACOMO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DeLEONEBUS, WIFE 4413 34TH STREET, BRENTWOOD MARYLAND 20722 ALICE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-5-99 FORT LINCOLN CEMETERY BRENTWOOD, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Saturd Licensee FORT LINCOLN FUNERAL HOME INC. 3401 BLADENSBURG RD, BRENTWOOD MD 20722 ullerie M00907 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one caused on each line. Approximate Interval Between Onset and Deeth Cerebrousenlas Accident Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last to (or as e consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation Injury

The law requires that the death certificete be executed physician end s the burial-transit P.O. Box 68760, d Se esn for u signed by the a Records. been certificate hes t director, page 2 s Division of Vital

Examiner Physician/Medicai þ Completed Hospital or Attanding Physician: 24 hours efter death.
Funeral Diractor: After this certifica tiely filled in by the funeral director, t Be To Certification:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be nutritled at

Pages 1 end 2 should be filed within 72 hours after deeth with nent of Health end Mental Hygiene.
Int: If Item 27 Ia marked other than "natural", or itams 23a or

7 la marked other traumatic avent, to

or other t

permit. Page Department of Important: If any Injury or

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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2

the Marylend

1 Yes 27. Manper of Death 1 Matural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

To the Hospital or Attar within 24 hours efter dea To the Funeral Diractor completely filled in by th 10 State

Medical

Registrar

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier Van MD 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

NOHAM PAR MAN AN D

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3331- TOLEDO TERRACE

31. Dete filed (Month, Day, Year)

APR 0 6 1999

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2001 8 8 1900 B

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 5, 1999 4c. County of Death Dziduch April 5:44 PM Charles Joseph /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** Prince Georges 8804 Crandall Rd. Lanham If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (in yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Days Yrs. Director Nov 11 1923 198-14-0598 Usuel Residence of Decedent Pennsylvania permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelith and Mental Hygiene. Important: If Item 27 is marked other than *netural; or thems 23a or 28a-f show any injury or other traumatic event the Mariana. 10d. Inside City Limits 10e State 10h County 10c. City, Town or Location 1 XYes 2 No Directo Maryland Prince Georges Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8804 Crandall Rd. U.S.A. 20706 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 [∆Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Western Union 12 Communications
18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adam Dziduch Agnes Ruchak 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Dziduch 8804 Crandall Rd. Lanham, Maryland 20706 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/9/99 Cheltenham, Maryland Maryland Veterans Cem. 21. Signati Funeral Servica Licans 22. Name end Address of Fecility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 Approximate Interval Between Onset and Death 23a. Parlf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only only course on each line. **Physician** 9 months /Medical Immediate Ceuse (Final Metastatic Non Small Cell diseese or condition resulting in deeth) Examiner Examiner physician and s the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed s certificate has by director, page 2 s 1 Yes 28 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical exeminer? funeral director Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated. 29a. Certifie Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

04/07/99

Oncology, Andrews AFB, M.) 20762

M) 057546-L (PENN)

State Registrar 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Den

B

31. Date filed (Month, Dey, Yeer) APR 0 7 1999 My

Registrar's Signature

Henatology

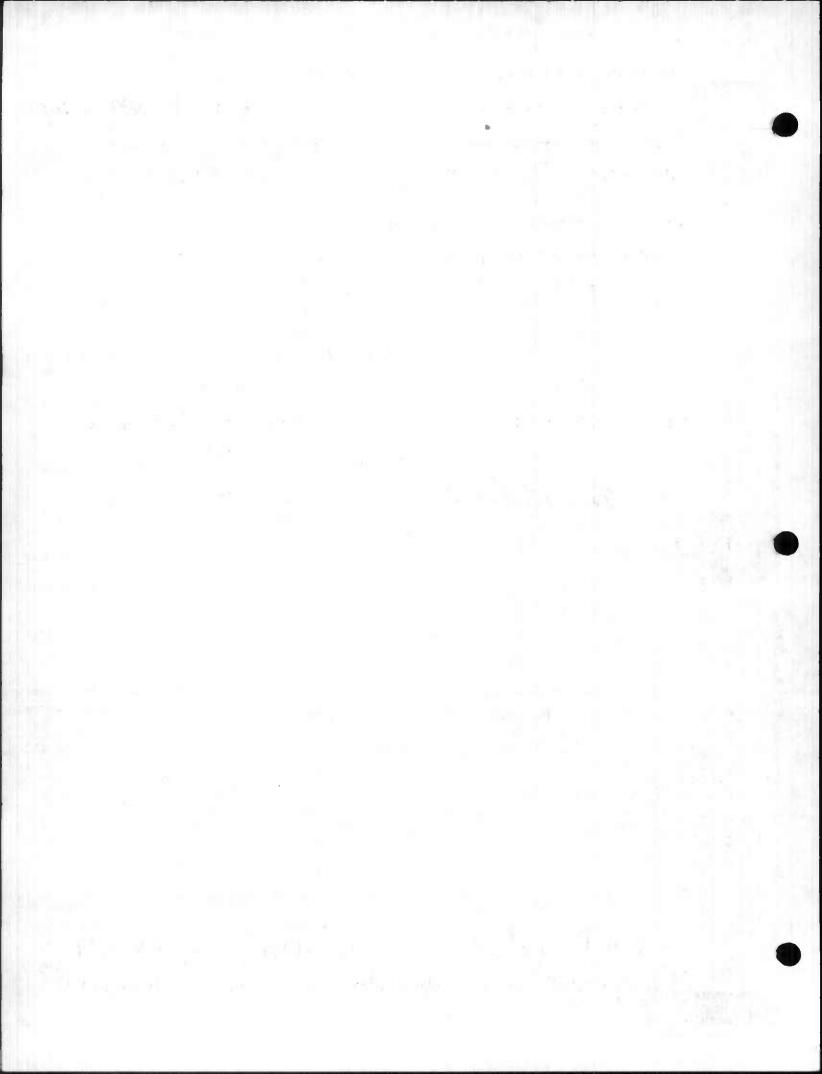
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| ysician /ledical | MARIA A DEMEN | Т | | | | | | | Month APRIL | 2, 19 | 99 | 10: | 30 AM |
| | ecility Neme (If not institution, give | e street end number |) | | | 4 | b. City, Tov | vn, or Loca | ation of Death | 4c. Count | y of Deeth | | |
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| ctor 2 | 17-98-4168 | ox □M 2⊠F | 31 | lest birthday) Yrs. | Months | | Hours | Min. | B. Date of Birth (Month, Dey, ECEMBER | Year) 15, 196 | WAST | | or Foreign |
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| MA 10e. | Street end Number | 1111 | | | | p Code | | | 1 | 0g. Citizen of | Whet Count | lry? | |
| <u>a</u> | 101 STATE STREE | T | | | 1 | 21666 | | | | UNITE | D STAT | CES | |
| Fur 1 | Marital Status ☐ Never Married 2 💢 Merried ☐ Widowed 4 ☐ Divorced | 12. Wes Deceden Armed Forces 1 Yes 2 It Yes, Give Yeer or Detes: | ? [No | | | | ispanic Orig n, Mexican, Specify: | jin? (Spec , Puerto Ri | ify Yes or No- ican, etc.) | | ca - America eck, White, e | etc. | |
| P | 15. Decedent's Ed | | | 16e. Dece | dent's Usi | el Occup | ation | | | 16b. Kind of E | | | |
| Completed | (Specify only highest greenentery/Secondery (0-12) | de completed) College (1-4or | 5.1) | (Give | kind of w | ork done | durina most | of working | 7 | | | | |
| mo. | 12 | College (1-40) | 3+) | ACCOU | NT R | ECEIV | ABLE | CLERI | K | PAPER | COMPA | NY | |
| 17. F | Fether's Neme (First, Middle, Last) | | | | | | 18. Mother | r's Neme (| First, Middle, I | Maiden Sume | me) | | |
| 0 | TOM McHAN | | | | | | JAC | KIE I | ELGUZZ | 0 | | | |
| | . Intormant's Name/Relationship (7 | Type, Print) | | 19b. Malli | ng Addres | s (Street | end Numbe | r or Rural | Route Number | , City or Town | n, State, Zip | Code) | |
| - | EORGE DEMENT-HU | SBAND | 100t D | 101 | | | treet, | , Ste | vensvi | | | | 566 |
| | Method of Disposition 1 △ Buriei 2 □ Cremetion 3 □ | Removei from Stete | | lece of Dispo emetery, crea | | | e) | | Dete | 20c. Location | - City or To | wn, Stete | |
| | 4 □ Donation 5 □ Other (Specify | 1) | | RT LIN | | | | | -99 B | RENTWO | OD, MA | RYLA | ND |
| 21.1 | Signature of Suneral Service Ligen | See Learn | mo | | | | s of Fecility | | HOME | | | | |
| er dise | ediate Ceuse (Finel lese or condition alting in death) | e | Due to (o | STATIC | quenca ot | : | F UNK | CNOWN | PRIMAR | Y | | | |
| Ceu thet resu | uentielly list conditions, y, leeding to immediate se. Enter Underlying se (Disease or injury initiated events liting in deeth) Lest | d | Due to (or | r as e consec | quence of) | | | | | | | | |
| Lia Lia | | | | | | | | | | | | | |
| Phy | tl. Other significant conditions or | ontributing to death | but not resi | ulting in the u | nderlying | cause giv | en In Pert i. | | | 23b. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknow | | | |
| Completed by | | | | | | | | | 24e. Wes e | n eutopsy med? | eve | ere autopsy eilebie prio mpletion of deeth? | r to |
| mo | | | | | | | | | 1□ Y | es 2⊠No | 10 | Yes 2 | □ No |
| @ 25. V | Was case reterred to medical exeminer? | | | | | | 26. Place | ot Death | (Check only or | ne) | | | |
| - 1 | Yes 2⊠ No | Hospitel: 1 ☐ Inpat | | ER/Outpetie | | | 4 LI NUI | rsing Hom | e 510 Reside | enca 6 🗆 OI | ther (Specify | 1) | |
| | Manner of Deeth Manner of Deeth Description Manner of Deeth Decident Manner of Deeth Decident | 28a. Dete of Inj (Month, D | ury ey Year) | 28b. Time o Injury | f M | 28c. Injur Wor 1 | yet k? Yes 2□N | 28d. Describe how injury occurred | | | | | |
| Certif | 3 Suicide 6 Could not be determined | 286. Place of it | njury - At ho | ome, term, str | reet, tacto | ry, office | | 28 | Bt. Location (S City or Town | | ber or Aura | l Route Nu | imber, |
| 1000 | | ysician: To the besi ntner: On the basis end menner s | of examine | | | | | | | | | | e(s) |
| | Signature and the of certifier | 1 | | | 29 | c. Licens | e number | | 2 | 9d. Dete sign | ed (Month, I | Dey, Year) | |
|) | 1 4119 | 4 | | | | DC | 19655 | | | 4/6 | 199 | | |
| | | completed cause of | | | | | | | | | | | |
| 24 5 | JOHN MARSHALL, M | | | | ROAI | , N. | W., W. | ASHIN | IGTON, | D.C. 20 | 0007 | | |
| State 31. 0 | APR 0 6 1999 | | trer's Signe | | line | زيمو | | | | | | | |

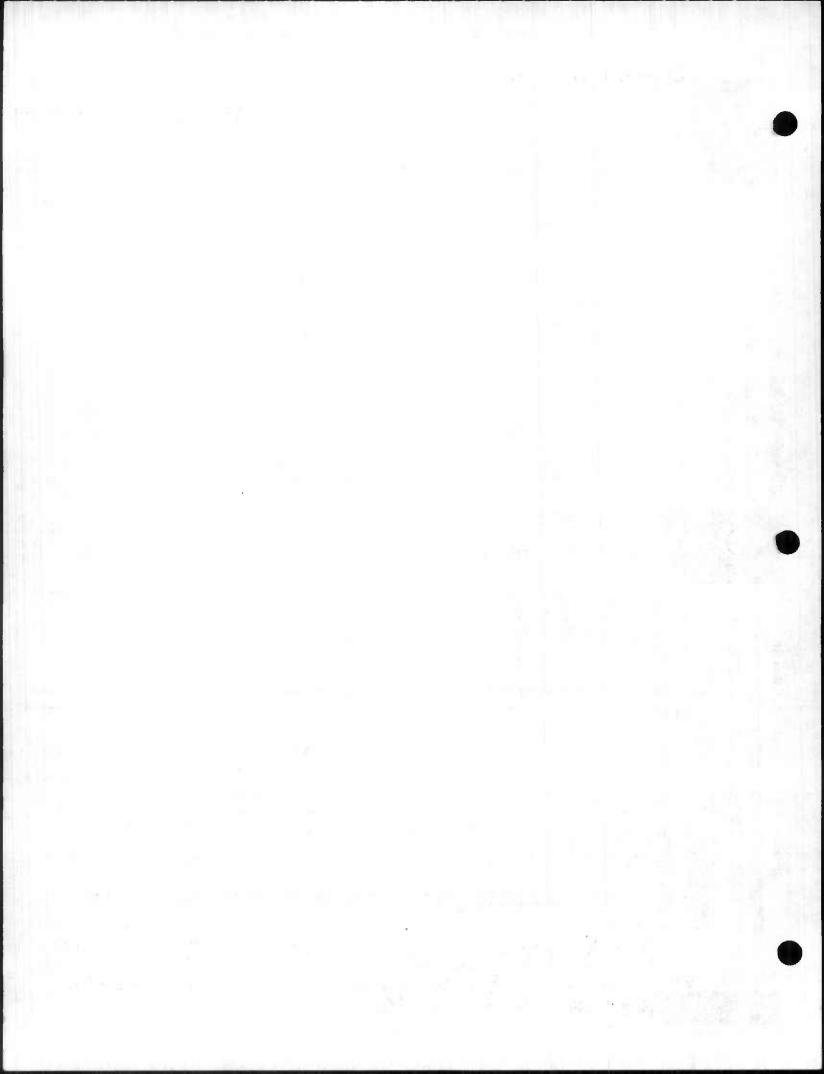
DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene Herman Certificate of Death Duckworth 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 4b. City, Town, or Location of Deeth Herman Duckworth 1100m N. /Medical 4e. Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Lion's Manor Nursing Home Cumberland
If Under 24 Hrs. 8 Allegany
9. Birthplace (State or Foreign Country) 5. Sociel Security Number If Undar 1 Year Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1XM 2□ F Months Days Hours Min. Yrs. Director 214-07-5231 87 March 13,1912 Maryland Usual Rasidanca of Dacedant the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. insida City Limits must be notified at Director 1 ☐ Yas 2 No MD Alleganv Rawlings 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 20009 McMullen Highway, S.W. 21557 Funeral USA items 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 11 Marital Status 13. Was Dacedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. the Medical Examiner filed within 72 hours efter 1 Naver Married 2 X Married 21215-0020 ŏ þ 1 ☐ Yas 2 ☑ No Spacify: Specify: 3 Widowed 4 Divorcad natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Spinning Department Textile Manufacturing traumatic event. Baltimore, Maryland 17. Fethar's Nema (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maidan Surname) Pages 1 and 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth jury or other traumatic even Be Nimrod Duckworth Vernie Lambert 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Elizabeth Duckworth/ Wife 20009 McMullen Highway, S.W. Rawlings, MD 21557 20b. Pieca of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Deta 1 XBurial 2 ☐ Cramation 3 ☐ Ramovel from Steta Department of Important: If any injury or once. April 11 4 ☐ Donetion 5 ☐ Other (Specify) Waxler Cemetery Rawlings, MD 21 Signatura of Funeral Service I Icenses 22. Nama and Addrass of Fecility Rotruck-Smith Funeral Home d 85 S. Main Street Keyser, WV 26726 23a. Part1. Entar the disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceusa on each line. Approximate Intarval Between Onset end Death Physician /Medical Immediata Cause (Final smonins disaasa or condition rasulting in deeth) Examiner Dua to (or es a consequanca of): Examiner DNani The lew requires that the death certificate be executed Sequantially list conditions, if eny, laading to Immadiata causa. Entar Undarlying Ceusa (Disaasa or injury that Initiatad evants rasulting In deeth) Lest and burial-tran Box 68760. the ettending physicien hed for use es the buna Physician/Medical Due to (or as a cor Part II. Other significant conditions computing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? es been signed by 2 should be detec 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown nertensoon þ Completed 24b. Ware autopsy findings evallable prior to complation of cause of death? 24a. Was an autopsy certificate hes domen. 1 Tas 2 1 No 1 ☐ Yas 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 ☐ Rasidanca 8 ☐ Othar (Specify) 2 1 ☐ Yas 2 No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Data of Injury (Month, Day Yaar) Certification: 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 5 Panding investigation deeth. 2 Accidant 1 ☐ Yas 2 ☐ No efter deeth Director: / the 3 Sulcida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) in by 4 Homicide within 24 hours e To the Funeral D Hospital edicai 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and pleca, and due to the causa(s) and mannar as steted.

2 Medical Examinar: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29e. Cartifiar pletely (Check only one) To the 29b. Signetura end titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Yaar) pleted cause of deeth (Item 23e) (Type, Print) 21502 mas ions Manor Nursing Home, Seton Drive, Cumberland 32. Registrar's Signature State Registrar



| | ., | Elizabeth J Delo | | | rtificate of | | 1 | ne 9 9 | 13115 |
|--|---------------------|---|--|------------------------------------|---|---|---|--|---|
| Physicia /Medica | al | Decedant's Nama (First, Middla, Last) Elizabeth Jan | | DeLo | | | 2. Data of Death Month | 1 | 3. Time of Death 9 8 30 an |
| Examine | er | 4a. Facility Nama (If not institution, giva street a Lions Manor Nursi | ng Home | | | 4b. City, Town, or L Cumberl | and | | llegany |
| Funeral Director | | 5. Social Security Number 213-24-5551 6. Sax 1 ☐ M 2 | - | 85 Yrs. | If Undar 1 Year Months Days | If Undar 24 Hrs. Hours Min. | 8. Data of Birth Month, Day Y | (ear) 1913 | rthplaca (Stata or Foraign |
| aryland | | 10a. Stata 10b. County | | City, Town or Lo | | | | | 10d. Insida City Limits |
| the Ma | ecto | MD Allegan 10e. Street and Number | Y | Cu | mberlan | ıd | 40- | OW IND - C | 1 No 2 No |
| h with | a Dir | 625 Elm Street | | | 10f. Zip Coda | 21502 | 109 | . Citizan of What C | ountry? |
| s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Med cal Examiner must be notified at | by Funeral Director | 1 Navar Marriad 2 Marriad 1 If Y | s Dacedant Evar in ned Forcas?. Yas 2 | | Vas Decedant of h f Yes, specify Cub 1 ☐ Yas 2 ☐ No | dispanic Origin? (Sp an, Maxican, Puarto Specify: | pecity Yas or No- Rican, etc.) | 14. Raca - Am Black, Wh Specify: w | ita, atc. |
| rithin 72 hona. | Completed by | 15. Dacedant's Education (Specify only highest grada comp | lated) lege (1-4or 5+) | (Give | | pation during most of work d) | ing | b. Kind of Businass | s/Industry |
| filed withi Hygiena. other than | | 17. Fathar's Nama (First, Middla, Last) | | Home | maker | 18. Mother's Nam | e (First, Middla, Ma | √n Home | |
| should be filed very marked other turnstic event, tr | To Be | Jacob Ludy | | | | Mary | (Todd) | | |
| th and the and the training training the training the training training training the training training traini | | 19a. Informant's Name/Ralationship (Type, Print Janet L. Stoops | nt) | 19b. Mailir 213 | g Address (Straet Chestnu | end Number or Runt Lane; | rel Routa Number, C Ridgeley | City or Town, Stete, WV 20 | Zip Coda) 5753 |
| Pages 1 and 3 nent of Health net: if item 27 I | | 20a. Method of Disposition 1 | from Stata | | natory or othar pla | | | c. Location - City o | |
| permit. Pages Department of Important: If I any Injury or sace. | | 21. Signatura of Funarai Sarvica Licansae | w/// | 22 | scarper | | 4/10/ (ral Homervland | | and, MD |
| Physician /Medical Examiner Street be executed by the private property of the private | edical Examiner | 23a. Pali 1. Entar the disaasa, or complications shock, or haart failura. List only one caus Immediate Ceuse (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Diseasa or Injury that initiated evants | Due to | n | uance of): | ^ | autic | 1 1 | Intarval Batwaen Onsat and Death |
| ath certification of the state | | rasulting in daath) Last | | | | | | | |
| 0 0 0 | | Parl II. Other significant conditions contribution Dicaliens Mellit | to death but not re | ssuiting in the ur so Huy | voi di | on in Part I. | 23b. Did toba | | e to the cause of death? Probably 4 Unknown |
| aw requir | | Hypertenseon, | Deme | ntia | H/o Pe | line for | 24a. Was an a performe | | Wara autopsy findings aveilable prior to complation of cause of death? |
| certificate ha | | 25. Wes casa referred to medical | | | | Of Place of Deck | 1 ☐ Yas | 2 0 No | 1 ☐ Yas 2⊠ No |
| this aldi | 2 | examiner? 1 Yas 2 No Hospital: | 1 ☐ Inpatiant 2 ☐ Data of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor | ar: 4 🗷 Nursing Ho | h (Check only ona) ma 5□ Rasidano 28d. Dascribe how | | ocify) |
| 2 # 5 E | | 3 ☐ Suicida 6 ☐ Could not be daterminad . 28e. | Place of Injury - At I building, atc. (Spec | homa, farm, stre | eat, factory, offica | | 28f. Location (Stree City or Town, S | et and Number or Fi Steta) | lurel Routa Number, |
| To the Hospital within 24 hours a To the Funeral is complately filled | | 29a. Cartifier (Check only one) 1 | o the best of my kn tha basis of axamin mannar stated. | owledga, daath ation and/or Inv | occurred et tha tin astigation, in my o | na, data and place, plnion, daath occurr | end dua to tha caus ed at tha tima, data | e(s) and menner a and place, end du | s stated. a to tha causa(s) |
| within To the compl | | 29b. Signature and titla of pertifiar | maimai stated. | | 29c. Licans | e number | 29d. | Data signed (Mon | th, Day, Year) |
| 6 | | V. H. Kaupth | ay. | M.D | - D | 19750 | A | pril 7 | , 1999 |
| State Registrar | 1 | 1.A. Ranjithan, M.D. Lior | causa of daath (Ite S Manor N 32. Ragistrar's Sign | Vursing 1 | | ton Drive | Extended, | Cumberla | nd MD 21502 |



99-2028-019 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene zoe rosemarie 5/4/99 J.A. Certificate of Death ITEM . 23 PARTILI 27 PER MEO G771 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Zoe Rosemarie Dyes APRIL 07, 1999 04:04 AM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Cambridge 8. Data of Birth (Month, Day, Year) 1, 1998 DORCHESTER DORCHESTER GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 KF Yrs. 218-53-6153 Maryland Director 4 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show unotified at show 1 Yas 2 No Directo Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à 4111 Sandy Knoll Drive 21631 USA Berra 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Race - American Indian, Black, Whita, etc. 11 Marital Status 21215-0020 1 Nevar Married 2 Married b 1 ☐ Yes 2 No Specify: Specify: White If Yas, Give Year or Datas: ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be tilt.
Department of Health and Mental Hy,
important if Item 27 is marked
any Injury or other the altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) å Mary P.Schwartz Charles Dyes 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mary P. Short/Mother 4111 Sandy Knoll Drive, East New Market, MD 21631 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Cambridge Crematory 14/10/99 Cambridge, Maryland □ Othar (Specify) 4 Donation 22. Nama and Address of Facility Zeller Funeral Home, P. O. Box 207, 21. Signatury of Funeral Service Life andu 106 Main Street, East New Market, MD 21631 confidications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause of each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) PNEUMONIA Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? o signed by t d be detact 1 Yes 2 No 3 Probably 4 Onknown 0 Records, p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yas 2□ No 1 Yes 2 No Division of Vitai Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TKYas 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? After Attending 1 Natural 5 Pending invastigation death. 1 ☐ Yes 2 ☐ No 2 Accidant hours after death 6 Could not be datermined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida b within 24 hours aft To the Funeral Dis completely filled in Medical 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME APRIL 07, 1999 Wyle

State Registrar

Педізмаг <u>АРР 1 2 199</u>

MANSONA

31. Data filed (Month, Day, Year)

30. Name and addrass of person who complet

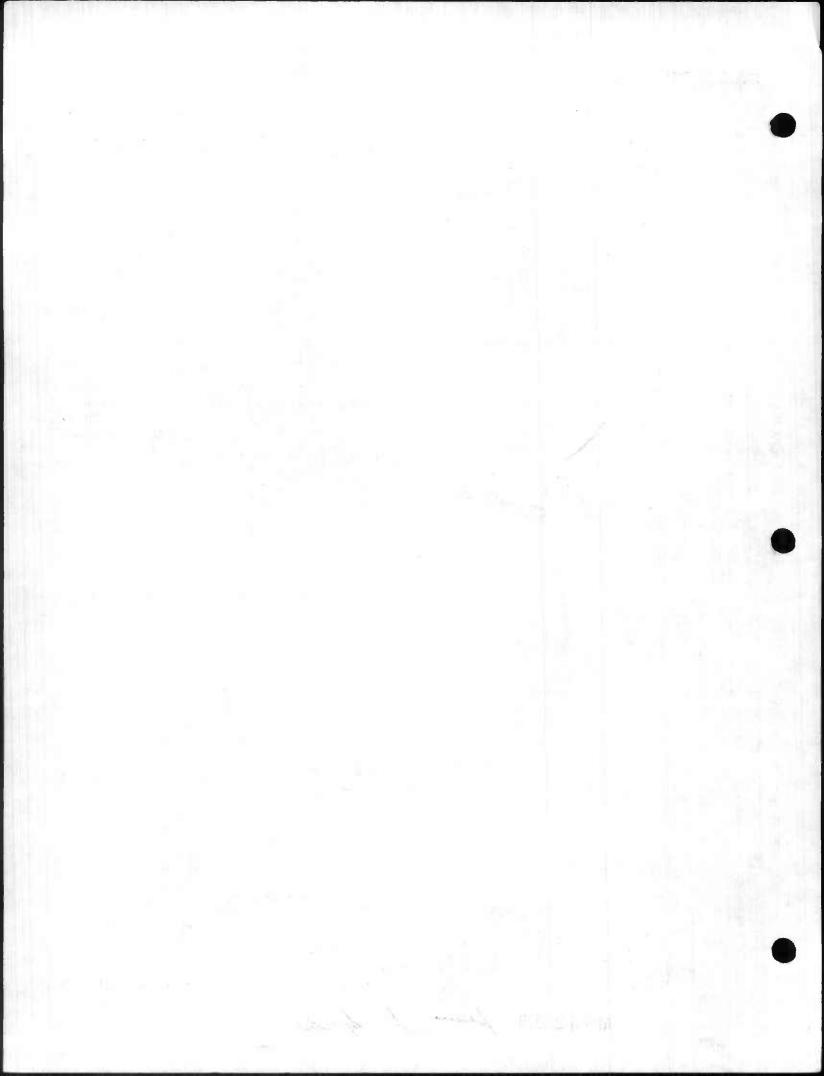
32. Registrar's Signatura

llope un

ed cause of death (Item 23a) (Type, Print)

B. Spals

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 1999 12:40PM April P. Elliott 4 Mary 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Long View Nursing Home Manchester Carrol1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Feb. 18, 1902 West Virginia 7. Age (In yrs. last birthday) if Under 1 Year 5. Social Security Number Days Months Hours 1 M 2 X F 215-32-9241 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. Stata 10b. County 1 Yes 2 No Carroll New Windsor Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 204 Lambert Ave. 21776 Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give 11 Maritai Status 1 Never Married 2 Married Specify White 1 ☐ Yes 2 ☐ No Specify: 3₺ Widowed 4 Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hospital/private duty nurse 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Thomas Elmer Marker Clara A. Carnev 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 21776 19a. Informant's Nama/Relationship (Type, Print) 204 Lambert Ave., P.O. Box 370 Donald B. Elliott/ son New Windsor, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/7/99 Parkwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facilit Hartzler Funeral Home of Fundal Service Licensee athanse 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each in the complex of the Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2ETNo 25. Was cese referred to medical 28. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Daath 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation Injury 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death. 24 hours a within 2 \$

Physician

/Medical

Directo

Funeral

p

Completed

Be

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Monical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumetic event.

Physician /Medical

Examiner

physician and the burial-transit

as esn. 10

signed by the a

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certificate

this funeral

After

director.

filled in by

Examiner

Physician/Medical

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Completed

Be

To

Certification:

Medical completely

29b. Signature

Baltimore, Maryland 21215-0020

the Maryland

with

death

State Registrar

31. Dete filed (Month, Day, Year) APR 0 7 1999

9111 4 32. Registrar's Signature

Aur m

30. Name and at dress of person who completed ceuse of deeth (Item 23e) (Type, Print)

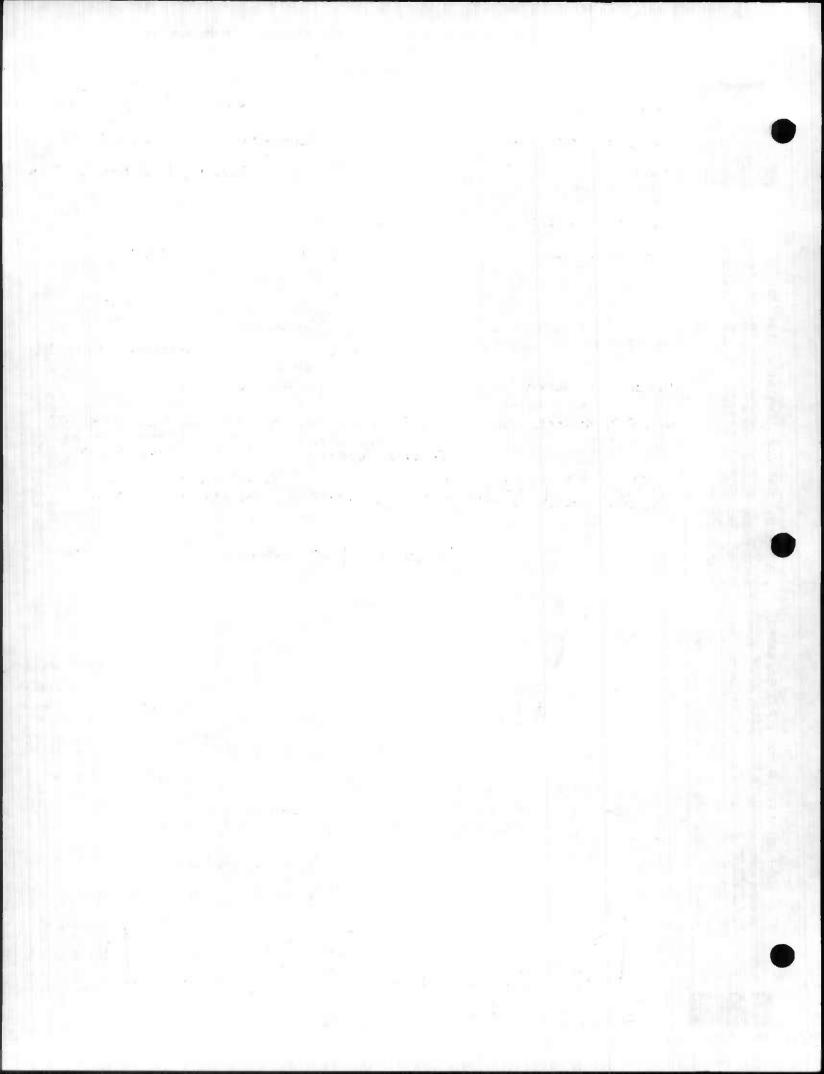
OWNER

29c. Licensa number

53165

29d. Date signed (Month, Day, Year)

DHMH 16 Ray 6/95



Please Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Year Ered ROY 131A 1999 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County General Hospital Westminster If Under 24 Hrs.] 8. Date of Birth CArroll 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) Months 12 M 2 F Yrs 93 215-44-8697 MASSACHUSE +ts Feb 20, 1906 Usuel Residence of Decedant 10a. Stata 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 N Vac 2 No Westminster MAryland CArroll 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Kose 21157 USA 226 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11 Marilel Status 1 Nevar Married 2 Married 1 Yes 2 No If Yas, Giva Yaer or Detes: 1 Yas 2 MNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRS TAX Accountant 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Cecotti (DAughter) 1048 Kentucky Blue Dr. West Mifflin, PA 15122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 图 Cramation 3 ☐ Removel from State 14/2/99 CArroll Cremation Inc Hampstend, 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Pritts Fineral Home + Chapel, P.A 21. Signifura of Funaral Sarvica Licensee 412 Washington Rd Westminster mD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final HERPES ENCEPHALITIS disease or condition rasulting in death) Dua to (or as a consequence of): teries ZOSTER Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

/Medical Examiner

Physician

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

Hygiena.

permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Itam 27 is marked other than any Injury or other traumetic avant, traingloud.

death

72 hours after

altimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

To

Funeral

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Completed

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Examiner Physician/Medical been signed by the should be detach by Completed f or Attanding Physician: after death. Director: After this certifica Be edical Certification: To To the Hospital or within 24 hours aft To the Funeral Discompletaly filled in

28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural

5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicida

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiar

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

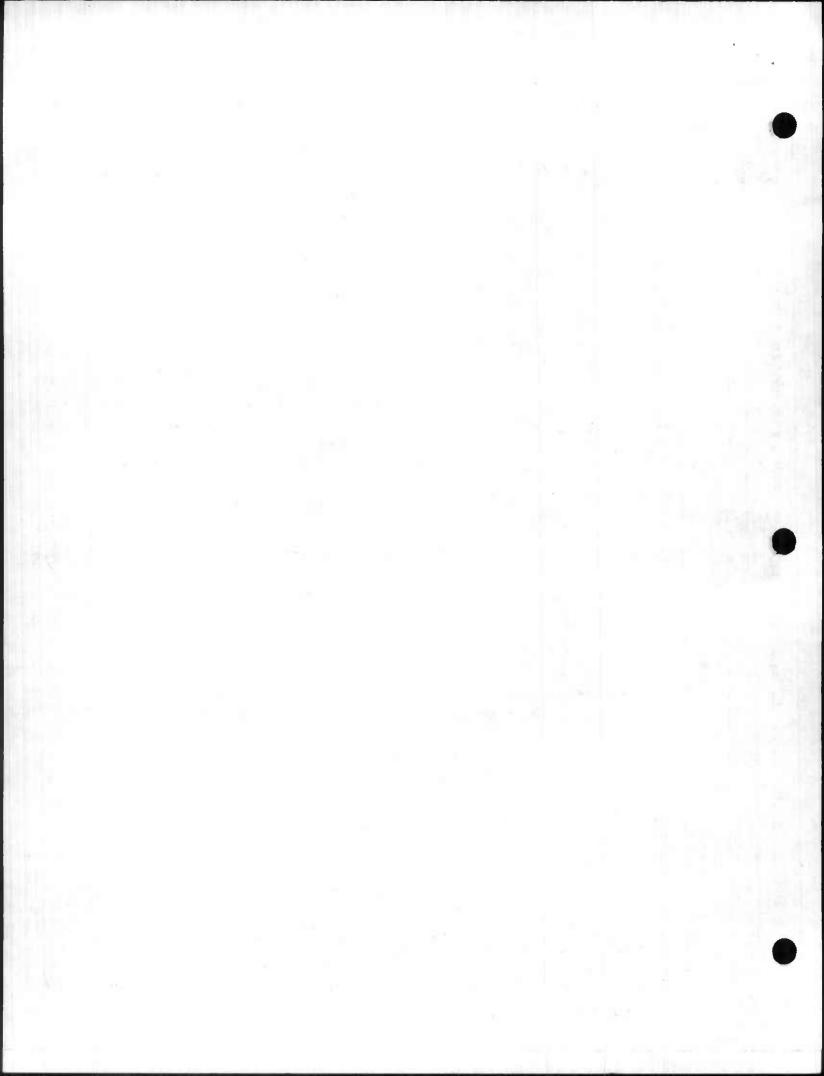
29d. Data signed (Month, Day, Year) 29b. Signatura and fitla of certifier 29c. License number ATTENDOVE PHYSICIAN

30. Nama end addrass of person who completed causa of death (Item 23a) (Type, Print)

904 WASHNETON PD WESMINSTER MOZIIS! PUDO ARTHUR L. MD 31. Data filed (Month, Day, Year)

State Registrar

32. Registrar's Signatura APR 0 5 1999



| | | | Ce | rtificate o | f Death | | F | Reg. No. |) [| 0112 | |
|--|--|--|------------------------------------|-------------------------------------|---------------------------------|--------------|---|---------------------------|--|--|--|
| Division | 1. Decedent's Name (First, Middle, I | ast) | | | | 2 | 2. Date of Dea | ath Day | Year | 3. Time of Death | |
| Physician /Medical | Louise | Catherine | Easterlin | 1 | | 1 | PRIL | 1, 199 | | 1:45 P.M. | |
| Examiner | 4a Facility Nama (If not Institution, g 8600 Mike Shaj | | #609 | | CLI | INTON | ation of Daath | PRINC | | ORGE'S | |
| Funeral Director | 5. Social Security Number 6. 225-36-7708 Usual Residence of Dacedent | Sex 1□ M 2√ F 7. Aga | (In yrs. last birthday, 67 Yrs. | Months Day | | Min. | B. Date of Birt (Month, Day Januar) | y 20, 1 | 9. Birthp Coun 932 A | place (State or Foreign stry) rlington, V | |
| Maryland at show | 10a. Stata 10b. County Maryland Prince | | 10c. City, Town or L | | | | | | 1 | 0d. inside City Limits 1 Yes 2 □ No | |
| 3e or 28 | 10e. Street and Number 8600 MIKE SHAP | | 10g. Citizen of V USA | What Cour | ntry? | | | | | | |
| d within 72 hours after deeth with the Maryland d within 72 hours after deeth with the Maryland gigner. The Macified Examiner must be notified at completed by Funeral Director. | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Ev Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates: | | Was Decedent of If Yes, specify Co | | | ify Yas or No- ican, etc.) | Blac | 14. Race - Amarican Indian, Black, White, etc. Specify: WHITE | | |
| "naturel", | 15. Decedent's (Specify only highast of | | 16a. Dece | edant's Usual Occ | supation ne durina mos | t of working | , | 16b. Kind of Bu | usiness/Inc | dustry | |
| - 4 - | Elamentary/Secondary (0-12) 5th | College (1-4or 5+ | life. | HOMEMA | ired) | | | DOMEST | ric | | |
| Be soft | 17. Fathers Nama (First, Middla, La | | | | | | | Maiden Sumam ISON BUY | | | |
| nd 2 lith au 27 le r trau | 19a. Informant's Name/Raiationship WAYNE EASTERLI | | | ing Address (Stre | | | | or, City or Town, MARLBOI | | | |
| mit. Pages 1 end 2 partment of Health portant: If item 27 I y Injury or other tr. | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec | | | osition (Name of omatory or other p | | 4- | Dete -9-99 | 20c. Location - | | | |
| permit. Pages Department of Important: If is any injury or once. | 21. Signature of Funaral Servica Lic | ensaa Bra | 1/201 | 2. Nama and Add | | | | FUNERAI | L HOM 2074 | | |
| Physician / Medical Examiner Ex | Immediata Causa (Final disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate | b | Due to (or as a conse | quence of): | Pan | are | es | | | 3 monts | |
| ortificate be ing physicie e es the bu | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last | c | ue to (or as a conse | quence of): | | | | | | | |
| at the death ce d by the attend latached for us. | Part II. Other significant conditions | | not resulting In the | underfying cause | given in Pert I | ı. | | tobacco use co | | o the cause of death? | |
| The law requires th the law requires the page 2 should be d | | Hor | | | | | 24a. Was perfo | an autopsy med? | av | ere autopsy findings aliabla prior to impletion of causa death? | |
| dictan: The law certificate has trector, pege 2 s | | | | | | | 103 | Yes 2000 | | ☐Yes 2☐No | |
| ysician: The last certificata ha director, pege | 25. Was case raferred to medical | | | | 26. Place | e of Death | (Check only o | ona) | | | |
| Physician: this certific rel director. | examiner? | Hospital: 1 ☐ Inpatien | | INT 3LI DUA | | | | denca 6 □Oth | | (y) | |
| To the Hospital or Attending Physician: The law requires the within 24 burus after doath. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by | 27. Manner of Death 1 atural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine | be on Blace of Injur | v - At home, farm, s | M 1 | ☐ Yes 2☐ | No | | | | al Route Number, | |
| Ne Hospital or no 24 hours afti ne Funeral Dir pletaly filled in edical Cert | 29a. Cartifier 1 Certifying I | Physician: To the best of aminer: On the basis of and manner state | my knowledga, dea | th occurred at the | tima, date an y opinion, des | nd place, ar | nd due to the | cause(s) and ma | annar as s | stated. o the causa(s) | |
| To the comple | 29b. Signatura and titla of certifiar | Sur | | | ensa number 46U | 78 | | 29d. Data signe | | Day, Year) | |
| (3) | 30. Name and address of person wh | | ath (Item 23a) (Type | | mD | 207 | +35 | | | | |
| State Registrar | 31. Data filed (Month, Day, Year) APR 0 5 1999 | 22. Registrar | 's Signature | boats | / | | | - | | 1 1 212 | |

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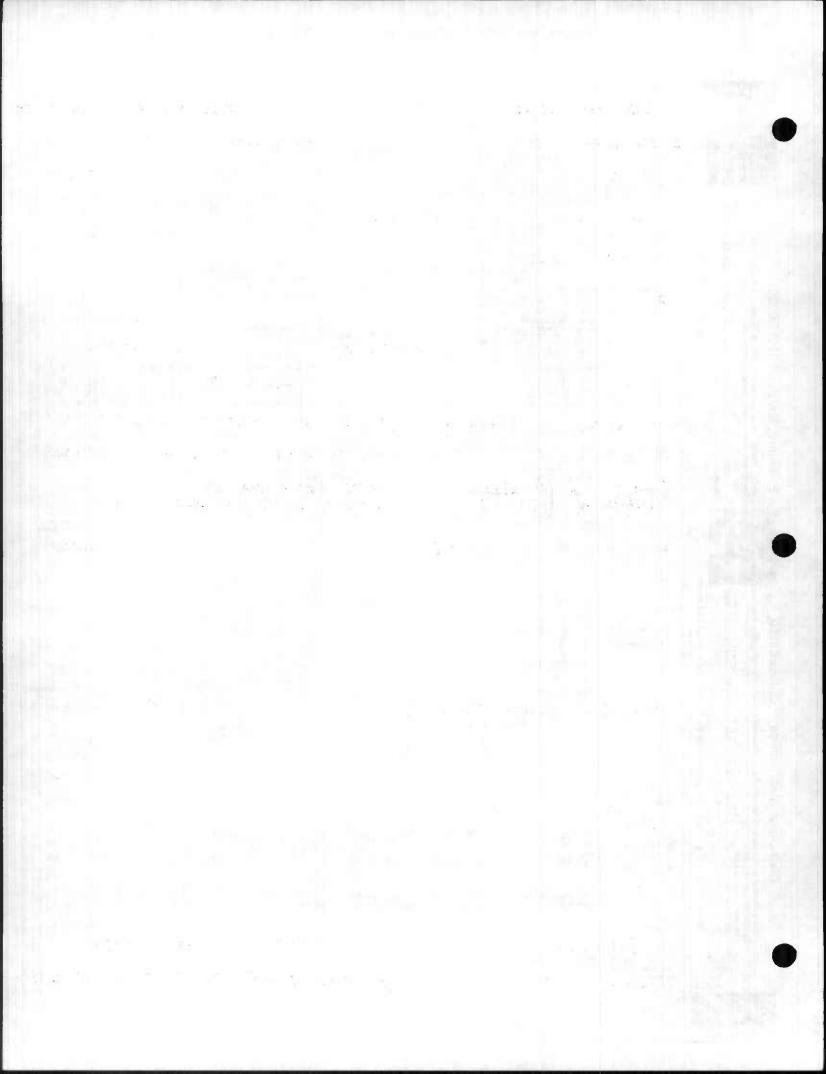
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 11,1999 IDA MAE ELDER 13:37 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner SACRED HEART HOSPITAL CUMBERLAND If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys 10 M 20 F 91 Yrs. Director 214-07-1505
Usuel Residence of Decedent SEPT 5 1907 MARYLAND with the Maryland r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits YOS 2 No CUMBERLAND MARYLAND ALLEGANY Directo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be r permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumstic event, the Medical Examine means bribas. 1414 BEDFORD STREET U.S.A. 21502 Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2√√No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER HOUSE KEEPER 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) DELLA MARTIN JOHN H. BOLDEN 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DAUGHTER 5638 JEFFERSON BLVD. FREDERICK, MARYLAND 21703 LINDA BRADOUR 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Burial 2 Cremetion 3 Removel from State ST LUKE'S CEMETERY APRIL 14 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND ax 1 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Physiclan DEPSIS House Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequenca of): Examiner certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequenca of): P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): 88 use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 s cartificate has 2 1 No 1 Yes 2 No Division of Vital 25. Wes case referred to medicel examiner? Be 28. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funaral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 1 Neturel 5 Pending n 24 hours efter death.

• Funeral Director: Alt bletaly filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 12 Cartifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. Medicai completaly 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. (Check only one) To the F within 2. To the F 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) my APRIL /2, 1999 5 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STAN DRUE CUMBERLAND, MD 26002 MAGBOJOS mo 6

32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month,



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) APRIL Dey MILDRED FRITZ 1999 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick

10f. Zip Code

7. Age (In yrs. last birthday)

Yrs

10c. City, Town or Location

Mount Airy

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

3. Time of Death

7:45 AM

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximete Interval Between Onset and Death

ISALL

3 Probably 4 ☐ Unknown

24b. Were eutopsy findings available prior to completion of cause of deeth?

2 No

21944

1 Tyes 2 No

Oct. 24, 1927 Maryland

10g. Citizen of What Country?

Race - American Indian, Bleck, White, etc.

Specify: White

Physician /Medical Examiner

Funeral

5. Social Security Number

219-20-2717

10e. Street end Numbe

10e. Stete

Maryland

Usual Residence of Decedent

10b. County

Frederick

6. Sex

1 M 2 TF

Director 28a-f show r than "natural", or items 23s or 28s-1 show

the Meryland with

Direct United States 14208 Peddicord Rd. 21771 Funeral death death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Status permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hyglene. Important: If frem 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Exercises PARE. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify by 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7th Grade Constuction Domestic Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Harry A. Stitely Mary (Unknown) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 12607 Layman Rd. Thurmont, MD 21788 Harry Ziegler (nephew) 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 ☐ Cremetion 3 ☐ Removai from Stete 4 □ Donetion 5 □ Other (Specify) 4/6/99 Locust Grove Cemetery Mount Airy, MD 21. Signeture of Funerals 22. Name end Address of Facility Burrier-Queen Funeral Directors, P.A. 23e. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate **Physician** End-stage COP.b. /Medical Immediete Cause (Finei disease or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physicien end for use es the buriel-transit The lew requires that the death certificete be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In death) Lest Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? ed by the deteched d be detech Yes 2 No skin LACIDUE AUBUNT ð 24e. Wes en autopsy performed? page 2 should Completed been 2 mes KI Osteoporosis

25. Wes case referred to medical examiner? After this certificate hes or Attending Physician: Be 26. Plece of Deeth (Check only one) To Hospitel: | Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) funeral 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury at Work? Certification: 1 Neturel 5 Pending investigation To the Hospital or much within 24 hours after death.

To the Funeral Director: After memorately filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. edical 29a, Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Typa, Print)

Grisson

32. Registrer's Signeture

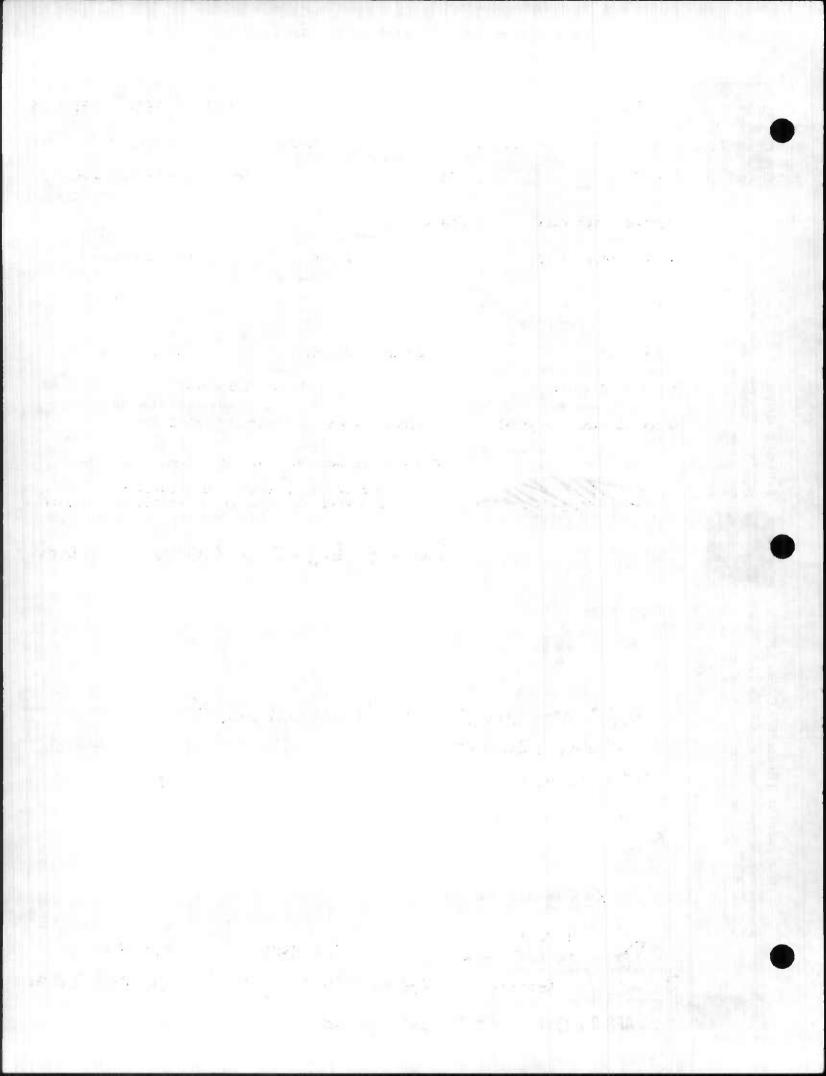
5

APR 0 7 1999

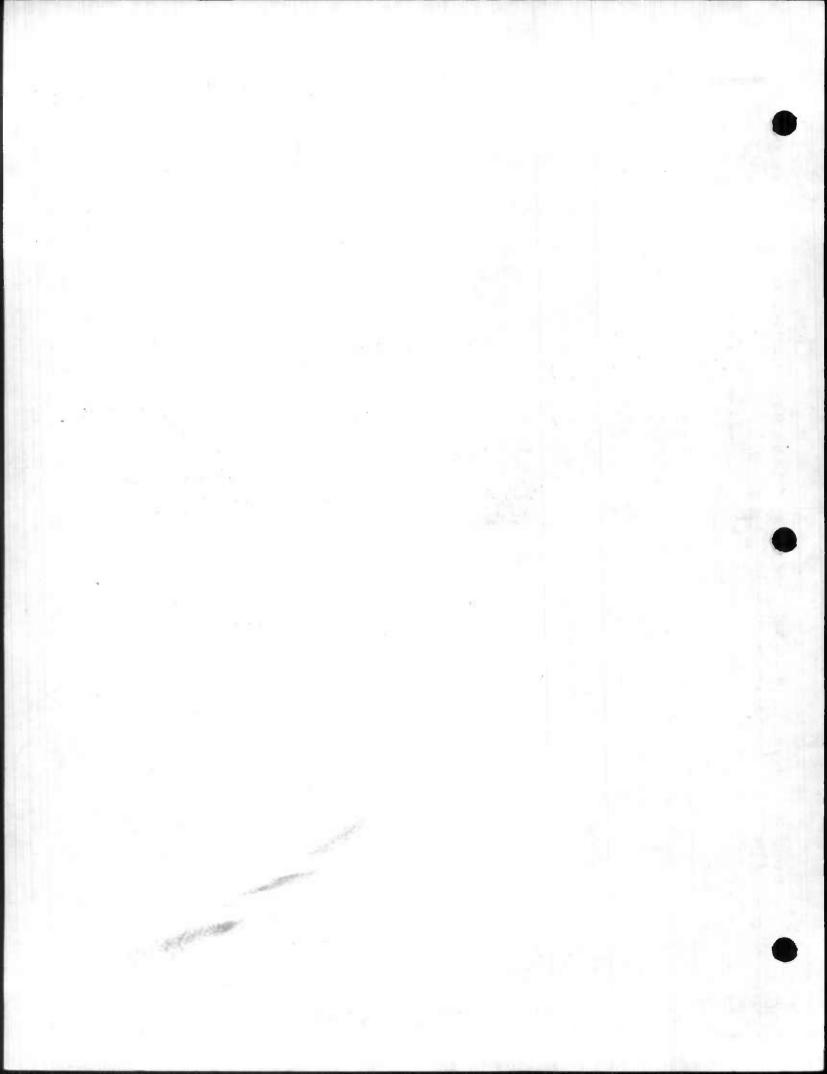
31. Dete filed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95



| | | | t of Health and Mental e of Death | Hygiene Reg. No. 99 13122 |
|--|---|---|--|---|
| Physician | 1. Decedent'a Neme (First, Middle, Last) Flora S. Flora | | | of Deeth 1 1 4 Day 1999 8:42 am |
| /Medical Examiner | 4a Facility Name (If not institution, give street and number) 600 Glynock Place | | | Death 4c. County of Deeth |
| Funeral Director | 220-10-5986 1□M ØF 8 | | 1 Year If Under 24 Hrs. B. Date (Month April | of Birth 9. Birthplace (State or Foreign Virginia |
| 2 ku | Usuel Residence of Decedent 10a. State 10b. County | 10c. City, Town or Location | | 10d. Inside City Limits |
| Mary art sh iffed a | MD Baltimore | Reisterstown | | 1 □ Yes 2 No |
| count with the Marys erns 23s or 28s-f sho er must be notified at rheral Director | 10e. Street and Number 600 Glynock Place | | | 10g. Citizen of What Country? USA |
| 2 2 2 2 | 11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Armed Forces? 1 Yes 2 Kryes, Give Year or Dates: | 1 ☐ Yes | 2 🖔 Specify: | or No- c.) 14. Race - American Indien, Black, White, etc. Specify: White |
| Maryland 21215-0020 2 should be filed within 72 hours at th and Mental Hygisen. th and Mental Hygisen. The marked other than "natural", or treumetic event, the Medical Exam To Be Completed by F | 15. Decedent'a Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5 | 16a. Decedent's Usua (Give kind of wo life. DO NOT u: +) Homemaker | al Occupation rk done during most of working se retired) | 16b. Kind of Business/Industry Domestic |
| yland 2 violate Hygenrian Hygenrian other ritic event, it | 17. Father's Neme (First, Middle, Last) Wilmer Stoneberger | | 18. Mother's Name (First, M Mary | fiddle, Maiden Symeme) E. DOVEL |
| - C - W - F | 19a. Informant's Name/Relationship (Type, Print) Lois Biller (daughter) | 19b. Meiling Address 5412 S. | (Street and Number or Rural Route N Klee Mill Rd. Sy | Number, City or Town, State, Zip Code) rkesville MD 21784 |
| Baltimore numit. Pages 1-1 bepartment of He mportant. If then ny injury or other since. | 20a. Method of Disposition 1 □ Surial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) | 20b. Place of Disposition (Nercemetery, cremetory or of Lake View Memo | ne of the prior Park 4/8/9 | 20c. Location - City or Town, State Sykesville MD |
| Balt permit Depart Import eny in | 21. Signeture of Funeral Service Licensee | | naight | |
| the death certificate be executed Whe death certificate be executed Whe attending physician and sched for use as the burial-transit Tysician/Medical Examiner | Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury) | 1 1 . 0 | | inona - July 1995 o carcinoma |
| Records, P is law requires that is hes been signed b ige 2 should be deten | Part II. Other algnificant conditions contributing to death by | | ng discase | 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? |
| = - 44 0 | 25. Was case referred to medical | | 26. Place of Death (Check | |
| Division of or Attanding Physical death. Street this in by the funeral distriction: To ortification: To | examiner? Yes 2 No | y Year) 28b. Time of Injury M | 8c. Injury at Work? 1 Yes 2 No 7, office 28f. Local | cribe how injury occurred tion (Street and Number or Rural Route Number, |
| To the Hospital within 24 hours a To the Funeral completely filled | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta | examinetion and/or Investigation, | 2. Date of Death April 4Pay 19695 8: 42 am 9: | |
| To the withing To the comp | 29b. Signature and title of certifier | ma. | 0 - 0 | 29d. Date signed (Month, Dey, Year) |
| | 30. Name and address of person who completed cause of de Dr. Karren Mirns 709 A | eath (Item 23a) (Type, Print) | + Boet wo | 21201 |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registra | r's Signature &. Af | ouls | |



| | Decedant's Nama (First, Middla, Last |) | Oerun | ficate of | Douin | 2. Data of Deat | eg. No. | 1 2 7 | Tima of Death |
|---|--|--|--------------------------------------|-------------------------------|--|---|------------------|--|--|
| nysician Medical | ROBERT | THOMAS | FLOYI | | | APRIL 5 | ,1999 | Yaar 7 | :08am |
| xaminer | 4a Facility Nama (If not institution, give | | | 4 | tb. City, Town, or I | ocation of Deeth | 4c. County | | a.c. |
| neral ector | 5. Social Security Number 6. Sa 579-56-3432 | | | f Undar 1 Yaar fonths Days | CLINTON If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day, April 1 | | 9. Birthplaca (Country) Washing | Stata or Foreign |
| | Usuel Rasidance of Decedent | | | | | | ,= | | |
| the Medical Examinat must be notified at completed by Funeral Director | 10a. Stata 10b. County | | y, Town or Locaf | ion | | | | | side City Limits Yes 2□No |
| Director | MD Prince Ge 10e. Street and Number | orges Cli | nton | 10f. Zip Coda | | 1 | 0g. Citizen of V | | |
| 5 | 9211 Stuart Lane | | | 20735 | 5 | | J.S.A. | rilet Courilly r | |
| Funeral | 11. Marital Stetus | 12. Was Dacedant Evar in U. | S. 13. Wa: | | Ispenic Origin? (S an, Mexicen, Puart | | 14. Raci | a - American Inc | dien, |
| by Fur | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forcas? 1XXYas 2 No If Yas, Giva Yaar or Datas: | | es, specify Cuba | Specify: | o Hican, atc.) | | Black | |
| ted | 15. Decedent's Edu | | 16a. Decedan | t's Usual Occup | ation | tina | | siness/Industry | |
| Completed | (Spacify only highast grad | College (1-4or 5+) | | | during most of wor | | 0011 | (D) (D) | |
| | 12th | | Printi | ng Appre | entice As | ssistant na (First, Middla, I | | | |
| Be o | 17. Fether's Nama (First, Middla, Last) Willie Floyd | | | | Irene V | | vieloan Sumam | 6) | |
| To | 19a. Informant's Nama/Ralationship (Tr | rpe, Print) | 19b. Melling | Address (Street | and Number or Ru | | . City or Town | Steta, Zip Code |) |
| | Jean J. Brown/ Ex- | , , , | | | lace, For | | | | |
| | 20a. We had of Disposition | | lace of Dispositi amatary, cramat | on (Name of | ce) | Dete | 20c. Location - | City or Town, S | tete |
| Depertment of Heel Important: If item 2 any Injury or other price. | 1 Burial 2 □ Crametion 3 □ F 4 □ Donation 5 □ Othar (Specify) | | | | Cem. 4/1 | 12/99 | | nam, Md | |
| | 21. Signeture of Funaral Sarvice Licens | . Sento. | | ama and Addra Kenned | y St., N. | hnson & .W. Washi | | | 0011 |
| | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | ications that causad the death ne cause on each line. | n. Do not antar t | ha moda of dyln | ng, such as cardiad | or respiretory arm | est, | Intar | oximete val Batwaan at and Daath |
| al er | Immediata Causa (Final diseesa or condition rasulting in death) | B | s/A+ 1 | | | | | | |
| ner l | | ? | Pulm | us Enpo | 1. | | | | |
| Examiner | Sequentially list conditions, if any, laading to immadiate | Dua to (o | r as a consequa | | | | | | |
| 部田 | Cause (Disaasa or Injury | Ø | Hylute | _ | | | | | |
| Medical | thef initiated evants rasulting in daath) Last | | r es à consequar | nce of): | | | | | |
| Physician/M | Part II. Other significant conditions con | d | ulting in the unde | riving causa div | an in Part I. | 23b. Did to | obacco usa cor | ntribute to the | cause of death? |
| | | | | , g ==== g v | | | es 2 No | | 4 🖳 Unknown |
| eted by | | | | | | 24a. Was a periori | | evaileble | topsy findings prior to ion of cause |
| Completed | | | | | | 1□ Y | as 25No | of deeth | |
| Be Co | 25. Was casa raferrad to medical | | | | 26. Place of Dog | eth (Check only on | | , L ras | 2010 |
| To B | examiner? | lospital: 1 Inpatient 2 | ER/Outpatient | 3□ DOA Oth | er. | loma 5 ☐ Raside | | ar (Specify) | |
| | 27. Mannar of Daath 1 PNatural 5 Panding 2 Accidant invastigation | 28e. Dete of Injury (Month, Dey Year) | 28b. Tima of Injury | 28c. Injur Wor | | 28d. Describe he | | | |
| Certification: | 3 ☐ Sulcida 6 ☐ Could not be determined | 28a. Place of Injury - At he building, atc. (Specify | | | | | | | te Number, |
| edical (| | sician: To the best of my knowner: On the basis of examinat and mennar stetad. | | | | | | | cause(s) |
| ž | 29b. Signature end fitle of certifiar | | | 29c. Licens | e number | 2 | 9d. Dete signe | (Month, Day, | Year) |
| | | Dan 00 0 | NA | D256 | 40 | A | pril 5, | 1999 | |
|) | 1 | - mi | | DZJO | 7-0 | | Prizi , | | |
| | 30. Neme end eddrass of person who co | | | nt) | | | - | | |

DHMH 16 Rev 6/95

400, 12 444

State of Maryland / Department of Health and Mental Hygiene

13124

| | | | Ce | ertificate d | or Death | | Reg. No. | | |
|---|--|--|---|--|--|---------------------------------------|--|---|--|
| | 1. Decedeni's Name (First, Middle, | Last) | | | | 2. Dete of De | | 3. Time of Death | |
| | Joseph Ralph | Fisher | | | | Month April | Dey 1. | 999 8:00 am | |
| | 4e Facility Neme (If not institution, | | | | 4b. City, Town, or | | | | |
| xammer | | | nton | | Charran | 1 | Daring | Coorgola | |
| | Prince George's 5. Social Security Number | | n yrs. last birthda) | If Under 1 Y | Chever | | | 9 Birthpiace (State or Foreign Country) | |
| | 578-16-9373 | 1M 2□F | 77 Yrs. | Months Da | ays Hours Min | 8. Dete of Bi (Month, Di Oct. 1 | ay, Year) | Country) Washington, DC | |
| ECTOI | Usual Residence of Decedent | | | | 1 | OCC. 1 | , 1721 | wastilligeon, bo | |
| ž u | 10a. State 10b. County | 1 | Oc. City, Town or L | ocation | | | | 10d. Inside City Limits | |
| ö | W1 D1 | C1- | | | 1 XYes 2 No | | | | |
| 00 | Maryland Prince | e George S | Hyatts | 10f. Zip Coo | ie . | | 10g. Citizen of V | What Country? | |
| 2 5 | | | | | | | | | |
| l e | 6409 Kilmer Str | | | | 0785 | D | | S.A. e - Americen Indian, | |
| au n | 11. Merilei Status | 12. Was Decedent Eve Armed Forces? | er in U,S. | If Yes, specify | of Hispenic Origin? (Cuben, Mexicen, Pue | to Rican, etc.) | | ck, White, etc. | |
| 8 > | 1 Never Merried 2 Marrie | If Yes, Give | | 1□ Yes 2K | No Specify: | | Specify | C TTL : A | |
| | 3 Widowed 4 Divorced | Yeer or Detes: [| WII | | | | | White | |
| 4 5 | 15. Decedent's (Specify only highest | Education arade completed) | 16a. Dec | edent's Usual Ode kind of work do | ccupation one during most of wo stired) | orking | 16b. Kind of Bu | usiness/Industry | |
| du | Elamantary/Secondary (0-12) | Coilega (1-4or 5+) | life. | | | | Bus Ind | | |
| Con | 12 | | | Mainter | nance/Repa | | | Greyhound Lines | |
| The Fullest Director. After this certification: To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director 17. Fether's Neme (First, Middle, La | ast) | | | 18. Mother's Na | me (First, Middle | i, Maidan Suman | 10) | |
| 0 | Emory Albernit | h Fisher | | | Ethe1 | Elizal | eth You | ung | |
| on: To Be Completed by Physician/Medical Examiner | 19a. Informent's Name/Raietionshi | p (Type, Print) | 19b. Mai | iing Addrass (St | reet and Number or F | iural Route Numi | ber, City or Town, | State, Zip Code) | |
| | M. Elaine Fisher | - Wife | 6409 | Kilmer | Street, H | vattsvi1 | le. Mary | land 20785 | |
| | 20a. Method of Disposition | | 20b. Place of Dist | position (Nama o | f | Dete | | City or Town, State | |
| | 1 N Buriai 2 ☐ Cremetion 3 | | | ematory or other | | 01/06/00 | | | |
| Cinic | 4 Donetion 5 Other (Spe | | Fort Lin | | | 04/06/99 | Brentwo | ood, Maryland | |
| DCG. | 21. Signature of Funerel Service Li | censos | | | ddress of Facility Funeral Ho | me PA | | | |
| 6 0 | A cons | lance / | | | timore Ave | | | e, MD 20781 | |
| | 23a. Part1. Enter the disease, or c shock, or haert feilure. List or | omplications that caused th | e death. Do not e | nter tha moda of | dying, such es cerdie | c or respiratory | arrest, | Approximata Interval Between | |
| cian | STOCK, OF FRANK I BILLIE. LIST OF | my one cause on each line. | | | | | | Onset and Death | |
| | immediate Cause (Final | 1 | | 1001 | - 0.0 | . 0 | | 1 1 1 | |
| ner | disease or condition resulting in death) | e | spence | rong | Felle | | | 144 | |
| e e | | Du | e to (or as a cons | equence of): | re lin | | | 7 *** | |
| i i | | b. Car | rees o | p 4 | e un | 9 | | SMO3, | |
| Xar | Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events | Du | e to (or as a cons | equance of): | | 1 | | | |
| Ш | ceuse. Entar Underlying Cause (Disease or Injury | C | | | | | | 1 | |
| dic | that initiated events reaulting in death) Last | Du | e to (or as a conse | equence of): | | | | | |
| ¥ | | | | | | | | | |
| an | | | | | | | | 1 | |
| 0 | Part ii. Other significant condition | a contributing to death but r | not resulting in the | underlying ceus | e given in Pert i. | 23b. Dic | tobacco use co | ntribute to the cause of death? | |
| thy | | | | | | 10 | Yes 2 No | 3 □ Probably 4 ₺ Unknown | |
| | | | | | | | | | |
| QP | | | | | | 24a. Wa | s en eutopsy | 24b. Wera eutopsy findings | |
| ete | | | | | | per | formed? | available prior to completion of cause | |
| np idu | | | | | | | | of death? | |
| | | | | | | 1 🗆 | Yes 2X No | 1 ☐ Yes 2 ☐ No | |
| O | | | | | 26. Place of Da | ath (Check only | ona) | | |
| 3e Co | 25. Was case referred to medical | | 2 ER/Outpati | ent 3 DOA | Other: 4 Nursing | Home 5 ☐ Res | sidence 6 Oth | ner (Specify) | |
| o Be | 25. Was case referred to medicel axaminar? 1 ☐ Yes 2 ☒ No | Hospital: 1 X Inpatient | | | - | | how injury occur | | |
| To Be | axaminar? 1 ☐ Yes 2 🔀 No 27. Manner of Death | 1 & Inpatient | 28b. Time | 01 200. | | 200. Describe now injury occurred | | | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | 28a. Data of Injury (Month, Day Y | 28b. Time Injury | M 280. | fnjury et Work? 1 □ Yas 2 □ No | | | | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident invastiga 3 Suicide 6 Could mic | 28a. Data of Injury (Month, Day Y | | М | 1 ☐ Yas 2 ☐ No | 28f. Location | (Street and Numl | ber or Rurel Route Number, | |
| To Be | axaminar? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending invastigations invastigations. | 28a. Data of Injury (Month, Day Y | - At home, farm, s | М | 1 ☐ Yas 2 ☐ No | 28f. Location City or To | (Street and Numb own, Stata) | ber or Rurel Route Number, | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident invastiga 3 Suicide 6 Could no datamin | 28a. Data of Injury (Month, Day Y stion at be ed 28a. Place of Injury building, etc. (| - At home, farm, s Specify) | M street, fectory, of | 1 ☐ Yas 2 ☐ No | City or To | own, Stata) | | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident 3 Suicide 4 Homicida 6 Could no datamin 29a. Certifier (Check only 2 Medical E | 1 A Inpatient 28a. Data of Injury (Month, Day Y 28a. Place of Injury building, etc. (Physician: To the bast of re | - At home, farm, s Specify) ny knowledga, dae aminetion and/or | M street, fectory, of | 1 ☐ Yas 2 ☐ No fice | City or To | own, Stata) | ennar as stated. | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident 3 Suicide 6 Could no datamin 29a. Certifier (Check only one) 1 Certifying 2 Medical Expansion | 28a. Data of Injury (Month, Day Y 28a. Place of Injury building, etc. (| - At home, farm, s Specify) ny knowledga, dae aminetion and/or | M street, fectory, of atth occurred at thinvestigation, in the street of | 1 Yas 2 No fice na tima, data and plac my opinion, deeth occ | City or To | own, Stata) a ceusa(s) and mo | ennar as stated. and dua to tha causa(s) | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident 3 Suicide 4 Homicida 6 Could no datamin 29a. Certifier (Check only 2 Medical E | 1 A Inpatient 28a. Data of Injury (Month, Day Y 28a. Place of Injury building, etc. (Physician: To the bast of re | - At home, farm, s Specify) ny knowledga, dae aminetion and/or | M street, fectory, of atth occurred at thinvestigation, in the street of | 1 ☐ Yas 2 ☐ No fice | City or To | a ceusa(s) and me, date and place, | ennar as stated. and dua to tha causa(s) and (Month, Day, Year) | |
| edical Certification: To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident 3 Suicide 6 Could no datamin 29a. Certifier (Check only one) 1 Certifying 2 Medical Expansion | 1 A Inpatient 28a. Data of Injury (Month, Day Y 28a. Place of Injury building, etc. (Physician: To the bast of re | - At home, farm, s Specify) ny knowledga, dae aminetion and/or | M street, fectory, of atth occurred at thinvestigation, in the street of | 1 Yas 2 No fice na tima, data and plac my opinion, deeth occ | City or To | own, Stata) a ceusa(s) and mo | ennar as stated. and dua to tha causa(s) and (Month, Day, Year) | |
| To Be | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastige 2 Accident 3 Suicide 4 Homicida 6 Could no datamin 29a. Certifier (Check only one) 2 Medical Expression of the certifier one) | 28a. Date of Injury (Month, Day Y) 28a. Place of Injury building, etc. (Physician: To the bast of remainer: On the basis of event manner states | - At home, farm, s Specify) ny knowledga, dae aminetion and/or i | M street, fectory, of ath occurred at the investigation, in a 29c. Like | 1 Yas 2 No fice na tima, data and plac my opinion, deeth occ | City or To | a ceusa(s) and m , date and piace, 29d. Date signe | ennar as stated. and dua to tha causa(s) od (Month, Day, Year) | |
| uneral director | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastiga 2 Accident 3 Suicide 6 Could no datamin 29a. Certifier (Check only one) 1 Certifying 2 Medical Expansion | 28a. Date of Injury (Month, Day Y) 28a. Place of Injury building, etc. (Physician: To the bast of remainer: On the basis of event manner states | - At home, farm, s Specify) ny knowledga, dae aminetion and/or id. | M street, fectory, of ath occurred at the investigation, in a 29c. Like | 1 Yas 2 No fice na tima, data and place my opinion, deeth occurrence number | City or To | a ceusa(s) and m , date and piace, 29d. Date signe | ennar as stated. and dua to tha causa(s) od (Month, Day, Year) | |
| uneral director | axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending invastige 2 Accident 3 Suicide 4 Homicida 6 Could no datamin 29a. Certifier (Check only one) 2 Medical Expression of the certifier one) | 28a. Date of Injury (Month, Day Y) 28a. Place of Injury building, etc. (Physician: To the bast of remainer: On the basis of event manner states | - At home, farm, s Specify) ny knowledga, dae aminetion end/or i | M street, fectory, of the occurred at the occurred at the investigation, in the street of the occurred at the | 1 Yas 2 No fice na tima, data and place my opinion, deeth occurrence number | City or To | a ceusa(s) and m , date and piace, 29d. Date signe | ennar as stated. and dua to tha causa(s) and (Month, Day, Year) | |

DHMH 16 Ray 6/95

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| | | 0. | | viai yiai | | | Health and f Death | u 1010111 | | g. No. | | 3125 |
|---------------------------------|---|-----------------|---|--------------------------------|--|------------------------------|---|----------------|--|-------------------|----------------------|---|
| | 1. Decedent's Neme (First, Mic | ddie, Last) | | | | | | | ete of Deet | h Dey | Yeer | 3. Time of Death |
| Physician /Medical = | Frederic | ck F1 | emming | 5 | | | | | ril | | 1999 | 10:30AM |
| | 4e Fecility Neme (If not institut | 7. 15 | | | | | 4b. City, Town, | | n of Deeth | 4c. County | ot Deeth | |
| | Southern M | | | | | Hadaa 4 Va | | nton | | | | orge's |
| Pirector | 5. Social Security Number 579-78-4075 | 6. Sex | | Age (in yrs. | M | Under 1 Ye onths Dey | | lin. (A | ete of Birth Month, Dey. | Year) , 1937 | | lace (Stete or Foreig try) nada |
| | Usuel Residenca of Decedent 10a. State 10b. Cour | ntv | | 10c. Cit | y. Town or Location | on | | | | | 1 | 0d. Inside City Limits |
| Irector | | • | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | , | 1 □Wes 2 □ No |
| 9 | District of | Colum | ola | | 1 | Of. Zip Code | hington_ | | 10 | 0g. Citizen of V | try? | |
| 0 | 5045 Ayers F | 20019 | | | | ed St | | | | | | |
| Funeral Director | 11. Meritel Stetus | 12. V | Ves Decade | nt Ever in U | ,S. 13. Wes | Decedent of | of Hispenic Orlgin? | (Specify | Yes or No- | 14. Rac | e - Americ | an Indien, |
| þ | 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce | larried 1 | rmed Force Yes 2 Yes, Give eer or Date | ĎNo | | | lo <i>Specify:</i> | ierto Hicar | i, etc.) | | ok, White, V: Wes | t Indian |
| P | 15. Deced | lent's Educatio | n | | 16e. Decedent | s Usuel Oc | cupetion | | | 16b. Kind of B | usiness/Inc | lustry |
| To Be Completed | (Specify only high | 1 | ollege (1-4a | or 5+) | (Give kind of work done during most of work life. DO NOT use retired) | | | | | | | |
| 0 | 12th | | | | F | ile S | pecialis | t | | Pri | vate | |
| Be | 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) | | | | | | | | | ne) | | |
| 0 | Fistroy Fl | Lemming | | | | | | Iren | e Lic | orish | | |
| | 19a. Informent's Neme/Reletic | | | | | | et end Number or | | | | | Code) |
| | Rosa Flemmi | ng - w | ire | Trace | | | Place, S | 1 | | | | |
| 100 | 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetio | n 3□Remo | vel from Ste | | Plece of Disposition cametery, cremators | n (Neme of ary or other p | oleca) | Da | ite | 20c. Location | City or To | wn, Stete |
| | 4 Donetion 5 Other | (Specify) | | | . Lincol | n Cem | etery | 4/6/ | 99 | Bren | twood | , MD |
| any Injury or other tr page. | 21. Signature of Funeral Service 23a. Part / Enter the disease, shock or heart failure. L | Ste | ns that caur | sed the deat | 4 | 001 B | dress of Fecility enning Refying, such es cere | d., N | LE. W | Funerash., | | 20019 Approximete Intervel Between |
| | In- distance (Steel | | _ | | | | | | | | | Onset end Deeth |
| | Immediate Cause (Finel disease or condition resulting in death) | | | | | | | | | Years | | |
| 100 | | | | | or es e consequen | ce ot): | | | | | 1 | |
| Examiner | | b | 1 | Senti | | | | | | | | years . |
| xa | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | | | | or es e consequen | ce of): | | | | | 1 | Years. |
| <u></u> | Cause (Disease or Injury that initiated events | c | | HTW | | 0 | | | | | | 100.3 |
| D | resulting in deeth) Lest | | | | r es e consequen | , | | | | | | -/- |
| n/Me | | d | | erdin | vand | _ 60 | Carles | | | | | 1000 |
| Physicia | Pert II. Other significant cond | itiona contribu | ting to deet | but not res | ulting in the under | tving cause | given in Pert I. | | 23b. Did to | bacco use co | ntributa to | the cause of death |
| by Physician/Me | | | | | | ,,,,, | | | 1 □ Y | es 2 No | 3 Proi | bably 4 Punknow |
| eted | | | | | | | | | 24a. Wes a perform | n eutopsy ned? | av | ere autopsy tindings allable prior to mpletion of cause |
| dw | | | | | | | | | 4 m s 1 | | | deeth? |
| Сомр | 25. Wes case referred to medi | ical | | | | | 00 01 | Death 10: | 1 🗆 Ye | | 11 | Yes 2□No |
| To Be | exeminer? 1 Yes 2 No | Hospi | tel: 1 1 Inpa | ation! of | ER/Outpetient | B DOA | 26. Place of Other: | | | | or (Co-sil | iv) |
| H | 27. Menger of Deeth | 28 | e. Dete of I | niury | 28b. Time of | 28c. lr | 4 LI NUISIII | sing Home 5 Re | | w injury occur | | r) |
| tlor | 1 Naturel 5 ☐ Pen | | (Month, | Day Year) | Injury | | Vork? ☐ Yes 2 ☐ No | | | | | |
| Certification: | 3 Suicide 6 □ Cou | ld not be | e. Piece of building, | Injury - At he etc. (Specif | jury - At home, ferm, street, tectory, | | ory, office 28f. Loca | | ocation (Street and Number or Rural Route Numb City or Town, Stete) | | | I Route Number, |
| edical C | | al Examiner: | | ot examine | | | time, dete end pl y opinion, deeth o | | | | | |
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| Σ | V | . 1 | | | 4. | | D 25640 | | | April : | | |
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| | A Name and 1 | | nad cause o | r deeth (Iten | n 23e) (Type, Prin | () | | | | | | |
| | 30. Name and address of person | | | | | | E #000 | * * | 1 . | - | | 0000 |
|) | Khosrow D | avachi | 132 32. Regi | 28 Sou | thern Av | e., S | .E. #202 | Was | hingt | on, D. | C. 2 | 0032 |
| | | avachi | 132 32. Regi | 28 Sou | thern Av | e., S | | Was | hingt | on, D. | C. 2 | 0032 |

112. * 111. 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend. 18 4/6/99 SM AACO Health Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death April 2, 1999 William Joseph Garvey 4:30 pm 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Annapolis If Under 1 Year | If Under 24 Hrs. | 8 Months | Days | Hours | Min. | Anne Arundel Medical Center Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1920 M 2□ F Months 215-40-6331 62 Yrs. Nov 28, 1936 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel 1 Yes 2 No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 St. Andrews Road USA 21146 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give 1962 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) State Farm Agent Insurance 18. Mother's Name (First, Middle, Meiden Surneme 17. Father's Name (First, Middle, Last) James F. Garvey, Sr. Gertrude A. Holbein Janice 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 14 St. Andrews Road, Severna Park, MD 21146 of Disposition (Name of Date 20c. Location - City or Town, State Janice Garvey / wife 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Apr Date 7 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Gardens 1999 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death failure. List only mediate Codse (Final Ceince Due to as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Obstruction June Percas

Physician /Medical Examine

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To the Hospital of within 24 hours at To the Funeral D

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r than "natural", or thems 23a or the Medical Examiner must be

d 2 should be filed within 7. Its and Mental Hygiene.
7 is marked other than "n al Hygione.

permit. Pages 1 and 2 at Department of Health and Important: If Itam 27 is n any injury or other traum

Maryland 21215-0020

Baltimore,

P.O.

Division of Vital Records,

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autopsy performed?

24b. Were autopsy findings aveileble prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Naturat

2 Accident

3 Suicide

4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigetion

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. tnjury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Plece of Death (Check only one)

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

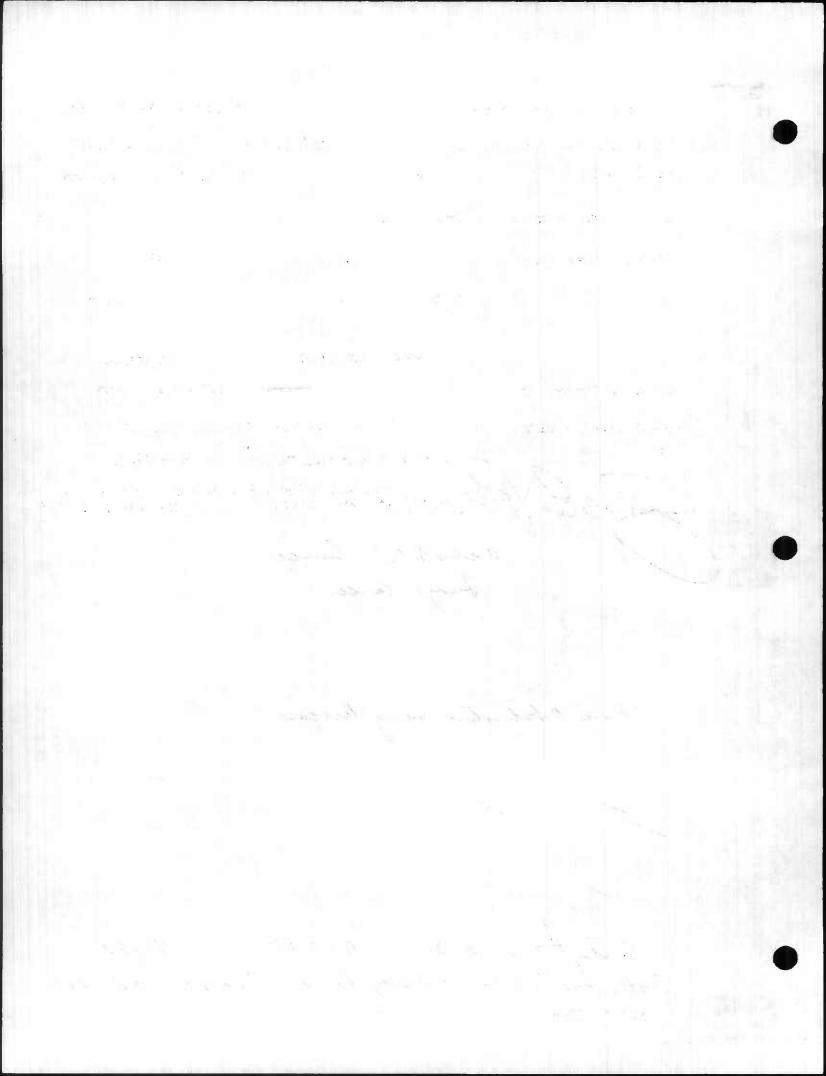
Carlin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Annapolis MD 21401 Harrism.D. 600 Ridgely 31. Date filed (Month, Day, Year)

Registrar

APR 0 6 1999

82. Registrar's Signature

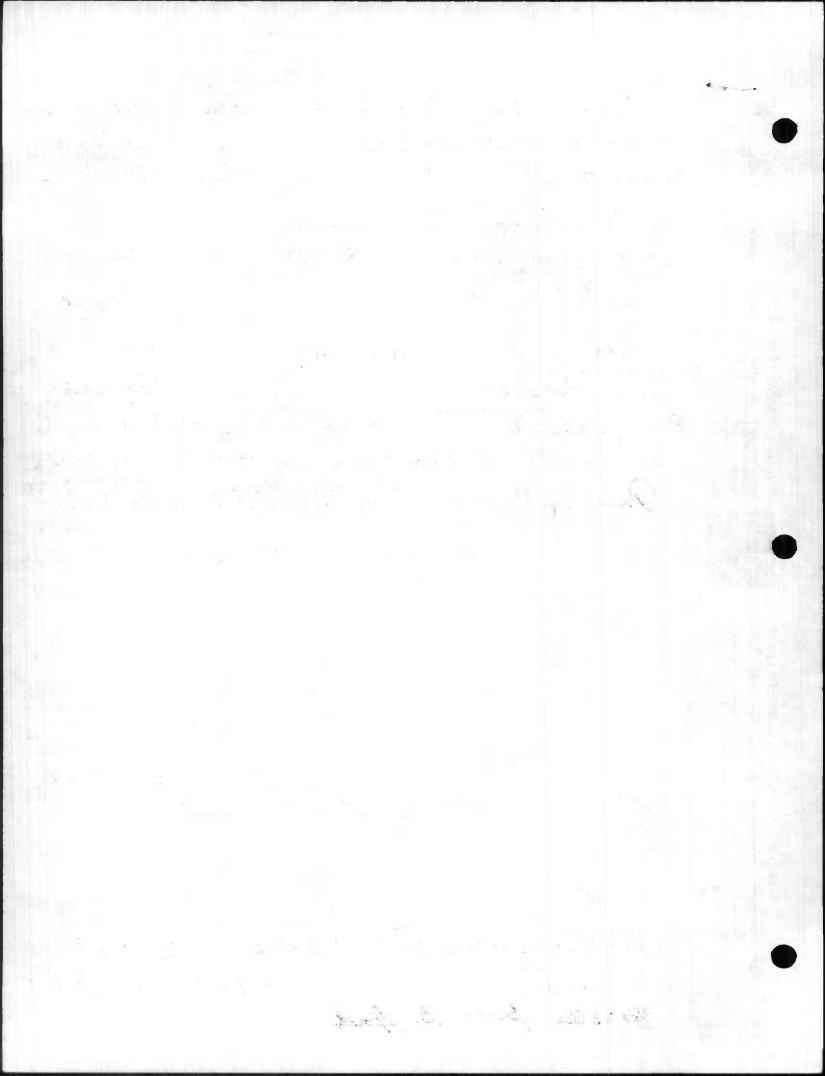


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #26.Per Phys. PGC 4-9-99 cr Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMONTH **Physician** 12 JOOCINQ 1999 Mae adle /Medical City, Town, or Location of Death 46. County of Death 4a Eacility Neme (If not Institution, give street and number) Examiner Hosp+Med 23 Meuer If Under 24 Hrs. 28008S eorg NOG INCO If Under 1 Year 8. Date of Birth Month, Day, 9. Birthplece (State or Abreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 M 2 F Yrs 077-28-157/ Usual Residence of Decedent 12/ Unginia **Director** Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiena. Int: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Yes 2□No Directo MD FINCE adensbur Georges 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or treumstic event, the Medical Examples roughber 20710 SA 6010)a by Funeral QN 09 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Biack, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ouse wife tome 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Dencer V 88 res OY 19a. Informant's Name/Relationship (Type, Prior) and -day. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207/0 Bladenburgy MI 20b. Place of Disposition (Name of cemetery, crematory or other place) way other t 20a. Method of Disposition Da 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o Burial 2 Cremation 3 Removal from State dward tamily RM 4 ☐ Donation 5 ☐ Other (Specify) -10 FRANKLIN.Co, Va 22. Name end Addless of Facility

Stanfie Mor

23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Serv St Koca Rock Moun Va Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician end s the burial-transk The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lasf Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of) attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an eutopsy s certificate has b 1 □ Yes 2 No 1 Yes 2 DAK the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica funerel director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Projector 6 Other (Specify) 1D es 2□ No 3 DOA Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner es stated.

2 Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil edicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 9 1999 Registrar



| | | | State of M | arylan | | rtment o | | | Mental Hy | giene (| 99 | 13 | 28 |
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| 5 | 0e. Street and Nu | | | | | 10f. Zip Co | | | | 10g. Chiza | an of What C | | |
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| 3 | | 15. Decedant's Ed | ducetion | | 16a. Daced | ant's Usual O | ccupati | on | | 16b. Kind | d of Business | /Industry | |
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| | Rafae1 | Gonzal | ez | | | | | Carmen | A. F1 | ores | | | |
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| | boll and | 12.1 | | -10 | mic | | | MA | RSHALL'S | FUNE | RAL HO | OME C | F MD |
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| P | art II. Othar signif | icant conditions o | ontributing to death b | ut not rasi | ulting In the un | dariying ceus | a givan | In Part I. | | | | | suse of death |
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| - | | | | | | | | | | an autops omed? | y 24b. | available | on of cause |
| | | | | | | | | | 10 | Yas 2 | No | 1 🗆 Yan | 2□ No |
| 2 | 5. Was case refar | red to medical | | | | | | Disease 15 | | | .10 | (85 | 20110 |
| 1 | axaminar? | | Hospital: | | FD/6 : | • | Othar: | | eth (Check only | | Clar: | 15 | |
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| - | 1 Netural 2 Accident | 5 Panding Invastigation | (Month, De | y Year) | injury | M 200. | Work? | es 2□No | 280. Dascribe | now injury | occurred | | |
| | 3 ☐ Sulcida 4 ☐ Homicida | 6 Could not be datarminad | 28e. Place of Injuding, at | | | at, factory, of | ffice | | 28f. Location (City or To | Street and wn, Stata) | Number or F | Rural Roul | ta Number, |
| 2 | 9a. Cartifier (Check only one) | | ysician: To the best ninar: On the basis o end manner st | f axaminal | | | | | | | | | ause(s) |
| 2 | 9b. Signatura and | title of certifier | | m m | | | icansa r | number 2564 |) | | signed (Mor | | Year) |
| | | · Da | -2- | 171 | | 1 | | 1 | | AFKIL | 1, 19 | 99 | |
| 3 | 0. Neme end eddr | ess of person who | completed ceusa of c | laath (Itam | 23a) (Type, F | Print) | | | | | | | |
| | KHOSROW | DAVACHT | M.D. 1328 | COII | THEDN A | MENTITE | T.7 | ASHING | DO NO | | | | |

5 State

Registrar

Physic /Medi Examir

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examiner must be not find an engage.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

KHOSROW DAVACHI, M.D. 1328

31. Dete filed (Month, Day, Year)

APR 0 5 1999

1328 SOUTHERN AVENUE
32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

| | | | | | nd / Depa <i>Cei</i> | tificate of | f Death | | Reg. No. | 0 1 | 0100 |
|---|--|---|-------------------------------|-----------------------------|-------------------------|--------------------------------------|-------------------------------|--|-------------------------|--------------|--|
| | 1. Decedent'a Nam | | | | | | | 2. Date of D Month | Day | Year | 3. Time of Death |
| | | DAY GIL | | | | | 4h Clhi Tour | APRIL or Location of Dee | | ty of Death | 3:40pm |
| 9 | 4a Facility Name (| LUMBIA | | imber) | | | LANDOVE | | | CE GEO | DOCEC |
| - | 5. Scolal Security N | | . Sex | | s. last birthday) | If Under 1 Yea | r If Under 24 H | rs. 8. Date of B | | | lace (State or Fore |
| | 238-54-63 Usual Residence o | | 1 M 2 □ F | 58 | Yrs. | Months Day | s Hours M | FEB 19 | | | H CAROLIN |
| | 10a. State | 10b. County | | 10c. C | City, Town or Lo | cation | | | | 1 | 0d. Inside City Lim |
| | MD | PRINCE | GEORGES | L | ANDOVER | 2 | | | | | 1 X Yes 2 □ I |
| | 10e. Street and Nu | | | | | 10f. Zlp Code | | | 10g. Citizen o | | |
| | 11. Maritel Status | LUMBIA A | | edent Ever in I | US 13 V | 2078 | | (Specify Yes or N | UNITED | STATE | |
| | | led 2⅓ Marrie 4 ☐ Divorced | Armed F | orces? 2 X No ive | | f Yes, specify Cu 1 ☐ Yes 2 🔯 No | | (Specify Yes or N erto Rican, etc.) | | ack, White, | etc. |
| | (Spec | 15. Decedent's cify only highest | Education grade completed) | , | 16a. Deced | dent's Usual Occ kind of work don | upation e during most of v | vorking | 16b. Kind of | Buainess/Inc | dustry |
| | Elementery/Second | ondary (0-12) | College (| (1-4or 5+) | | DO NOT use retii EER SPEC | | GOVERN | | | יידי |
| | 17. Father's Neme | (First, Middle, Li | ist) | | ENGINE | SER SIEC | | me (First, Middle, Maiden Sumame) | | | N.T. |
| | JOHN GI | LLESPIE | | | | | ETTA S | TEELE | | | |
| | 19a. Informant's N | | | | | | Rural Route Num | | | Code) | |
| | FLORINE . | | SPIE / Y | WIFE 20b. | | COLUMB sition (Name of | IA AVE, | LANDOVER | ,MD 207 | | own State |
| any injury or | 1X Burial 2 | ☐ Cremation 3 | Removal from | State | cemetery, crer | natory or other p | | 4/7/99 | | | |
| | 21. Signature of Fu | 5 ☐ Other (Spe uneral Servica Li | | r | | NCOLN CE | Iress of Facility | | | WOOD, | AD |
| | Van | e L | Li. | | > . | | | OPE FUNE KE, FORE | | | 7/7 |
| | 23a. Part1. Enter t | he disease, or c | omplications that | caused the dee | 1 | | | | | , FID Z | Approximate Interval Between |
| | Immediate Ceuse- disease or condition resulting in death) Sequentially list confiant, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) | onditions, nmediate orlying injury | b | Due to (CO) | (or es e consec | PIDE puence of): | | 015 | ord)E | | YEARS |
| | | | d | | | | | | | | |
| | Part II. Other signif | licant condition | contributing to d | leath but not re | esulting In the u | nderlying cause | given in Part I. | 23b. Did | tobacco uee d | ontributa to | the cause of dea |
| | Be | Y NEW | ~ Pro | tota | ier | Jazoh | zement | 10 | Yes 2DA | 3 Pro | bably 4 Unkn |
| | | V | | | | | 0 | | s en eutopsy formed? | av co | ere autopsy finding alleble prior to mpletion of cause death? |
| | | | | | | | | 1 🗆 | Yes No | 10 | ☐ Yes 2☐ No |
| | 25. Wes case refer examiner? | rred to medical | 11. | | | | | Death (Check only | one) | | |
| | 1 Yes 2 7 | 1 | | | ☐ ER/Outpatier | IL SLI DOA | Other: 4 Nursin | | sidence 8 C | | (y) |
| | 27. Manner of Deat 1 Naturet 2 Accident 3 Suicide | 5 Pending investiga | tion | of Injury oth, Day Year) | 28b. Time of Injury | M 1 | ☐ Yes 2☐ No | | Street and Nur | | al Route Number, |
| | 4 Homicide | determin | ea build | ling, etc. (Spec | oify) | out, ractory, offic | | City or To | own, State) | or rure | |
| 29a. Certifier (Check only one) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| | non Diversities and | title of partifiers | 2 | | | 29c. Lice | nse number | 9 | 29d. Date sig | dia (Money) | G G |
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| | 1/ | W. L | one, M | se of death (Ite | 100 /11 | Print) PELCAN- | tile LA | #135 0 | LAKS | o, 12 | d 207; |

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| ysician | | ne (First, Middle, La | | h | | | | 2. | Dete of Dee Month | | 3. Time of Deet | |
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| dical | | y Lillia (If not institution, giv | | | | | 4h City To | wn, or Locat | April | 1 1 1 | 1:39AN | |
| ner | | ern Maryl | | | | | | inton | NOTE OF EGGET | 1 | ince George's | |
| | 5. Social Security N 578-50- | | Sex 7 | 7. Age (In yrs. 88 | | If Under 1 Yea Months Deys | r If Under | 24 Hrs. 8. Min. | Dete of Birth (Month, Dey, | Year) 4 1910 | 9. Birthplece (State or For Country) Maryland | |
| | Usuel Residence o | f Decedent 10b. County | | 10c Cit | y, Town or Loc | cation | | | | | 10d. Inside City Lin | |
| 0 | | Prince (| George's | 100. 01 | | mple Hi | 11s | | | | 1 Tyres 2 | |
| i Directo | 10e. Street end Nu | | | | | 10f. Zip Code | 20748 | 3 | 1 | Og. Chizen of Wi | | |
| by Funeral | 3 Widowed | ried 2 Married | 12. Wes Deced Armed Ford 1 12 Yes 2 If Yes, Give Year or De | ces? 2 🗆 No | 11 | Was Decedent of f Yes, specify Cu | ben, Mexicer | n, Puerto Ric | y Yes or No- an, etc.) | | - American Indien, ; White, etc. | |
| Completed | (Specification) | 15. Decedent's E- cify only highest gra ondary (0-12) | | 4or 5+) | (Give | lent's Usuel Occu kind of work done DO NOT use retir Maid | e during mos | st of working | | 16b. Kind of Bus | | |
| ğ | 17. Fathers Neme | (First, Middle, Last, | | | | natu | 18. Moth | | Private Neme (First, Middle, Maiden Surmeme) Mary Evans | | | |
| L _o | Charles Beander Charles Beander Mary Evans 19a. Informent's Name/Reletionship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street end Number or Rural Route Number, City or Town</i> , | | | | | | | | State, Zip Code) | | | |
| | | ph L. Cui | • | ephew | | - 24th | | | | | 20748 | |
| | 20e. Method of Dis | - | Removel from S | 20b. F | Plece of Dispos cemetery, crem | sition (Neme of netory or other pl Lvet Cem | (ece) | | | | D.C. | |
| | 21. Signature of Fi | nerel Service Licer | tour : | A 111 | 7 22 | Name end Add | | . Sti | | Funeral ash., D. | Home .C. 20019 | |
| | Immediate Cause disease or condition resulting in death) | on | plications that ce one cause on ee | ch line. | | 0 | | | espiretory err | est, | Approximete Intervel Between Onset end Deeth | |
| line. | | | | Due to (c | or es e conseq | uence of): | · | | | | Α, | |
| n/Medical Examiner | Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in deeth) | rinjury | | Ove to (c | | uence of): | | | 7 | | V | |
| edical | ceuse (Disease or thet initiated event resulting in deeth) | rinjury | b. 180 | Due to (o | or es e consequences | uence of): | my | zath | | | tribute to the cause of dea | |
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| Physician/Medical | Part II. Other signif | flighty Lest | b. So. | Due to (o | or es e consequences | uence of): uenca of): nderlying ceuse g | given in Pert | gath. | 1 ☐ Y 24e. Wes e perform | on eutopsy med? | 3 Probably 4 Unkr 24b. Were eutopsy findin eveileble prior to completion of ceuse of death? | |
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The state of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Certific | ate of | Death | | Reg. No. | 1 3 | 101 |
|--|--|--|--|--|---|---|---|--|--|-----------------------------------|--|
| oion | 1. Decedent's Ner | me (First, Middle, La | | | | | | 2. Dete of De Month | eeth Dev | Year | 3. Time of Death |
| ciạn Iical | WHITN | EY | GIST | | | | | 4-6- | | Ē | 5:35am |
| iner | 4a Facility Neme | (If not institution, giv | e street end number |) | | | 4b. City, Town, or I | ocation of Deel | th 4c. County | of Death | |
| | 5 | SHADY GR | | | HOSPI | | ROCK | | | TGOME | RY |
| r r | 5. Social Security 150-42 Usual Residence | -7956 | Sex 7. A | ge (In yrs. last | Yrs. If Ur | ths Days | | 8. Dete of Bir (Month, De 5-16 | rth ey, Yeer) -52 | Country) | e (State or Foreig |
| | 10a. Stete | 10b. County | | 10c. City, To | own or Location | | | | | 10d. | Inside City Limits |
| 0 | MD | Montgo | omerv | Gai | thersh | ourq | | | | | 1 X Yes 2 □ N |
| Director | 10e. Street and N | | | | | Zip Code | 79 | | 10g. Citizen of 1 | Whet Country | 7 |
| ra | | | | | 10.111.5 | | | | | a American | to dian |
| by Funeral | | rried 2 X Married 4 Divorced | 12. Was Decedent Armed Forces 1 Tes 2X If Yes, Give Yeer or Dates: | 7 | if Yes, | specify Cu | Hispanic Origin? (S ben, Mexican, Puert o Specify: | pecify Yes or No o Rican, etc.) | Bla | ce - American ck, White, etc. | |
| Completed | /Sn: | 15. Decedent's Ed | | 1 | 6a. Decedent's l | Usuel Occu | upation | 16b. Kind of Busin | | usiness/Indusi | try |
| nple | Elementary/Sec | | College (1-4or | 5+) | | | e during most of wor | ning. | Government | | |
| So | | | 4 | 1 | robati | ion (| Officer | | | | |
| Be | | e (First, Middle, Last, | | | | | | ne (First, Middle, Meiden Surneme) | | | |
| 2 | Whitn | ey E. (| Gist | | | Barbara Curry b. Malling Address (Street end Number or Rural Route Number, City or Town, Ste | | | | | |
| | 19a. Informant's i | Name/Relationship (| | | | | | | | | |
| | Vera G | Sist - W: | lfe | | 20033Ma | atti | ngly Ter | r,Gait | hersbu | rg, MD | 20879 |
| | | isposition 2 Cremation 3 C 5 Other (Specif | | ceme | of Disposition of tery, cremetory | or other pi | · N | Dete -6-99 | 20c. Location Rockvi | | |
| | 21. Signature of F | Funeral Service Licer | De Ma | tee | | | ress of Facility Unnedy St, | | | | |
| | 23a. Part . Enter shock, or he | r the disease, or come eart failure. List only | plications that cause one cause on each | d the death. E | o not enter the | mode of dy | ying, such es cardied | or respiratory | arrest, | Int | oproximate terval Between nset and Deeth |
| | Immediate Ceuse disease or conditi resulting in death | tion | · ch | olang. | utis | | | | | 5 | days |
| 7 | | , | 0 | | a consequence | of): | | | | | - 1 |
| Ë | | | b. 15ac | terem | q | | | | | | day |
| Examiner | Sequentially list of if any, leading to cause. Enter Und | conditions, immediate | | Due to (or es | e consequence | | 0 | | | | 1 |
| Wedical | Cause. Enter Onc Cause (Disease of that initiated even resulting in death) | or Injury hts | c. accom | Due to (or as | e consequence | of): | fi ci enc | 7 84, | n dyonne | | Jeans |
| ysicia | Pert II. Other sign | nificant conditions of | ontributing to death | out not resultin | g in the underlyi | ng cause g | given in Pert I. | | tobacco use co | | |
| by Phys | | | | | | 1 | Yes 2 No | 3 Probab | ly 48 Unknow | | |
| | | | | | | | | | | 1 | |
| by | | | | | | | | | s en eutopsy ormed? | evaila | eutopsy tindings ble prior to letion of cause th? |
| by | | | | | | | | perf | | evaila compl of dea | ble prior to letion of cause |
| Completed by | 25. Wes case refe | erred to medical | | | | | 26. Place of De | perf | Yes 2 No | evaila compl of dea | ble prior to letion of cause ith? |
| o Be Completed by | exeminer? | erred to medical | Hospitel: | ient 2□ER | Outpatient 3 | DOA C | ther | perf | Yes 2 No | evaila compl of dea | ble prior to letion of cause ith? |
| To Be Completed by | exeminer? 1 Yes 2 | No ath | 28a. Date of Inj | ury 28 | b. Time of | AOUL | ther: 4 Nursing H | perf | Yes 2 No | evaila compl of dea 1 \(\sum Y\) | ble prior to letion of cause ith? |
| To Be Completed by | exeminer? 1 Yes 2 27. Menner of Dea Natural 2 Accident 3 Suicide | No ath 5 Pending investigation 6 Could not be | 28a. Date of Inj (Month, D | ury 28 ay Year) | | 28c. Inj W | hther: 4 Nursing F ury at ork? □ Yes 2 No | perf 1 □ ath (Check only) iome 5 □ Res 28d. Describe | Yes 2 No one) ildence 6 Oth how injury occur (Street end Numi | evaila compi of dea 1 Y | ble prior to letion of cause th? |
| Certification: To Be Completed by | exeminer? 1 Yes 2 27. Menner of Dec Natural 2 Accident 3 Suicide 4 Homicide | No ath 5 Pending investigation 6 Could not be determined | 28a. Date of Inj (Month, Di | ury Year) 28 jury - At home tc. (Specify) | b. Time of Injury M , farm, street, fac | 28c. Inj W 1[ctory, office | hther: 4 ☐ Nursing F ury at ork? ☐ Yes 2 ☐ No | ath (Check only lome 5 Res 28d. Describe 28f. Location City or To | Yes 2 No one) idence 6 Ott how injury occur (Street end Numi | evaila compile of dea 1 2 Y | ble prior to letion of cause th? es 22 No oute Number, |
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I'm the agree of the fact that the same of the same of

Annual Company of the
Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Madical Examiner mast be notified at

permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Health end Mental Hygien with more influent if Itam 27 is marked other than "natural", or then any Injury or other traumetic event. The Merican

3altimore, Maryland 21215-0020

the Meryland

deeth

ettending physician and for use es the bunel-trensit this certificate has

Completed Be 10

Examiner Physician/Medical Certification:

Box 68760, P.O. Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, of Division

VIOLET

HAGAN,

VAME:

Medicai 29a, Cartifian 29b. Signatura at

31. Data filed (Month, Day, Yeer) State Registrar

APR 0 5 1999

5 Panding Invastigation

6 Could not be datarmined

32. Registrar's Signature

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

1 Yas

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 15504

2 No

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Typa, Print)

2300 Dulaney Valley Rd Eddie Nakhuda, M.D.

Timonium, Md 21093

28f. Location (Street end Number or Rural Route Number, City or Town, State)

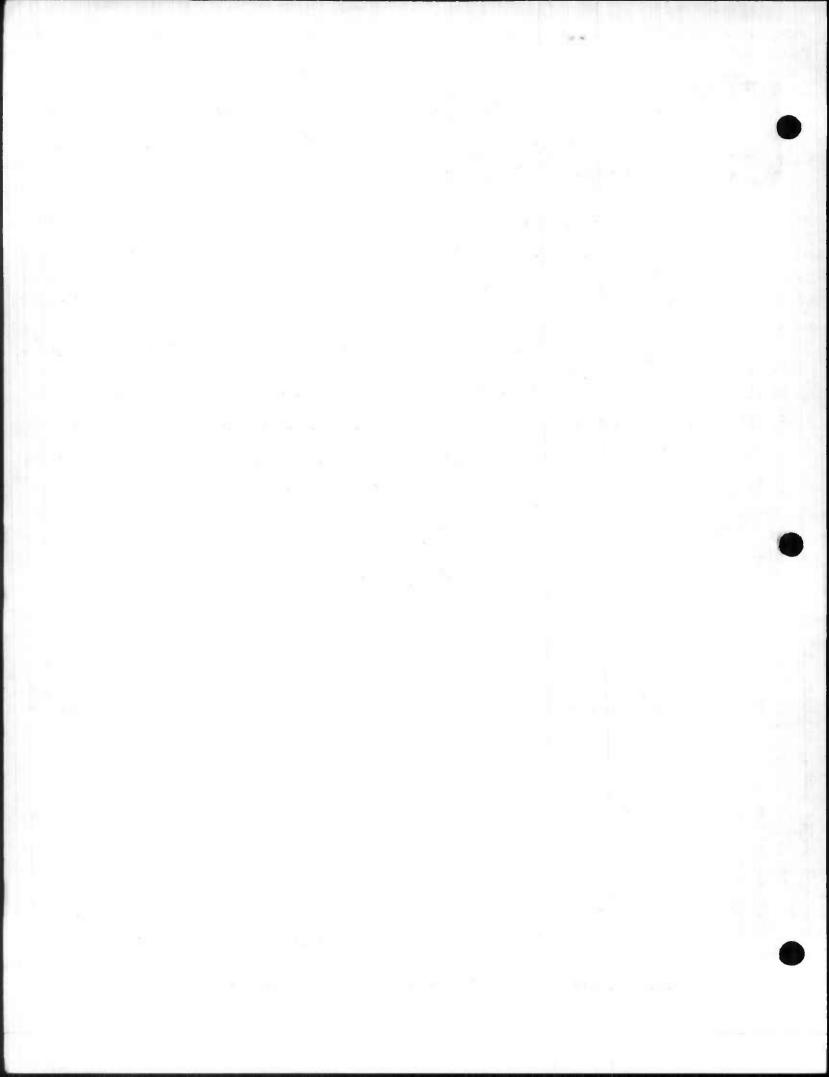
29d. Data signed (Month, Day, Year)

1 DN Natural

2 Accidant 3 Sulcida

4 Homicida

(Check only one)



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| 11 | | | Decedent's Neme (First, Mid | do (ant) | | Certific | cate of | Death | O Date of D | Reg. No. | | 0 7 0 0 |
|--------------------------|--|--|---|--|-------------------------------|--|-----------------------------------|--|---|--------------------------------------|--------------------------------------|--|
| | Physic /Medi | | Lucille | Judene Ho | od | | | | 2. Dete of De Month March | Dey | Yeer 999 | 3. Tima of Deat 11:04 P |
| | Exami | | 4a. Facility Neme (If not institut | |) | | | 4b. City, Town, or | | h 4c. County | of Deeth | |
| | Funeral | | Civista Medica 5. Social Security Number 577-42-8555 | + | ge (In yrs. Id | | Inder 1 Year | La Plata If Under 24 Hrs Hours Min | 8. Dete of Bi | Charley, Year | | ace (Stete or Fore |
| | Director | | Usuel Residence of Decedent | . XXX | 70 | Trs. | | | Janua | ary o, 1 | 929 | NC NC |
| poopoo | show | 2 | 10e. Stete 10b. Coun | | | , Town or Location | 1 | | | | 10 | d. Inside City Lin |
| M od | 26.91 | ecto | MD Char | les | Wal | dorf | 7 0 1 | | | | | XXXes 2□ |
| division di | 23a or 28a-f show | rai Dir | 1098 Derset | Drive | | 10 | f. Zip Code 2060 | 2 | | 10g. Citizen of V USA | Vhet Countr | y? |
| 5-0020 | at', or items | Completed by Funeral Director | 11. Maritel Status 1 Never Married 2 Ma 3 Widowed 4 Divorce | If Yes Give | Ever in U,S No | | ecedent of he specify Cub | dispenic Orlgin? (S an, Mexicen, Puer Specity: | Specify Yes or No rto Ricen, etc.) | | e - America k, White, et Black | |
| 5-0 | natur | eted | 15. Decede | nt's Education est grede completed) | | 16e. Decedent's | Usuel Occup | etion during most of wo | orkina1- | 16b. Kind of Bu | isiness/Indu | istry |
| Maryland 27215-0020 | Department of Health and Maniel Hygiens. Department of Health and Maniel Hygiens, important: if item 27 is marked other than "natural", any injury or other traumatic event, in a Healte Exagnes. | Somple | Elementery/Secondery (0-12) | | 5+) | Draftin | | 11 8 | Patent | | | of Comme |
| land | entel Hy ked oth ic event | To Be | 17. Fether's Neme (First, Middle John Ar | | | | | | me (First, Middle | Melden Sumem | Θ) | |
| a Z | umat umat | - | 19e. Informent's Name/Reletion | ship (Type, Print) | | 19b. Meiling Add | iress (Street | end Number or R | | 0 | Stete, Zip C | Code) |
| Σ, | alth 27 i | | LaVera F. M | arshall/daug | hter | 2504 | Dawso | n Court | Temple H | Hills, M | D 207 | 45 |
| Baltimore, | ant of He it: If item y or oth | | 20e. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other | 3 Removel from Stete | | ece of Disposition metery, cremetory | | | Dete 4/5/99 | 20c. Location - | | |
| | ortan injur | | 21. Signeture of Funerel Service | | 111 | nity Mem | | ss of Facility W | | | | aryland |
| מ פֿ | Depa impo | | 12 1 00 1 | F 8-00 | 10- | | | ruder Fu | _ | | | Jr., Ave |
| 68760, | physician end strength strengt | edical Examiner | resulting In deeth) Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that intiteted events resulting in deeth) Lest | b | Due to (or | es e consequence es e consequence es e consequence | of): | 15 | | | | |
| death certifi | | Physician/Me | | d | | | | | | | 1 | |
| | 9 9 | sicia | Pert II. Other eignificant condit | one contributing to death t | out not resul | ting in the underly | Ing ceuse giv | ren in Pert I. | 23b. Did | tobacco uee cor | itribute to t | the cause of dea |
| , T. 14. | ed by detac | by Phy | | | | | | | 1 🗆 | Yee 2 No | 3 Proba | ably 45 Unkn |
| Hecords, | pinod | Completed t | | | | | | | | en eutopsy ormed? | evail | e autopsy finding lable prior to pletion of ceuse seth? |
| - F | cate. | | | | | | | | 1 🗆 | Yes 2 No | 1 🗆 | Yes 2 No |
| Of Vital | s certificate has t director, pege 2 s | Be | 25. Wes cese referred to medic examiner? | Hospitel: | | | Oth | | eth (Check only | | | |
| Ing Phy | After this funeral of | ion: To | 27. Menner of Death 1. Neture 5 Pend | 28e. Dete of Inju | ıry | ER/Outpetient 3E 28b. Time of Injury | 28c. Injur Wor | 4 Li Nursing i | T | dence 8 Other | | |
| DIVISION at or Attending | within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral | Certification: | 3 ☐ Suicide 6 ☐ Could | nined 200. Place of in | jury - At hor c. (Specify) | ne, farm, street, fe | | res 2 NO | 28f. Location (City or To | Street end Numb wn, Stete) | er or Rural i | Route Number, |
| Hosolt | 24 hour Funera etaly fills | edical (| 29e. Certifier 1 Certify (Check only one) | ng Phyelcian: To the best Examiner: On the basis o end menner st | f exeminetic | ledge, death occu on end/or investiga | rred et the tir ation, in my o | ne, dete end place plnion, deeth occ | e, end due to the urred et the time, | ceuse(s) end me dete and plece, s | nner es ste and due to t | ted. he cause(s) |
| othe | Vithin To the | Me | 29b. Signeture end title of certif | | | | 29c. Licens | e number | | 29d. Dete signed | (Month, D | ey, Year) |
| 1 | | | Defelia 1 | 1. Tagani. | U.D | | D - | 50883 | | 3-29- | 99 | |
| 1/ | 7) | D - 50883 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) St. Mary's Hospital Yahia M. Tagouri, MD 25500 Pt. Lookout Road, Leonardtown, Maryla | | | | | | ospital | Dept. c | | hology | |
| (| 1 | | iania M. Taccur | i MD 25500 D | + T - | alrout D | J T . | . 1. | 14 | 1 00 | | 0, |

DHMH 16 Rev 6/95

Judene

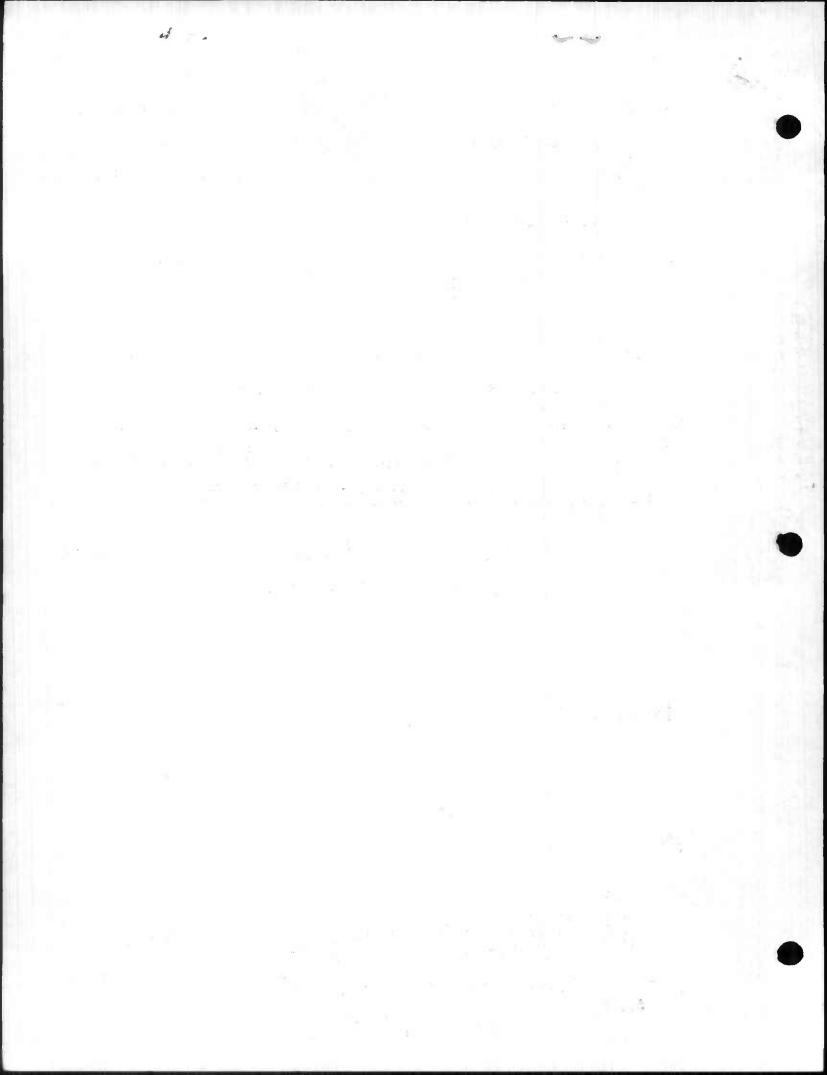
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Places Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** NOAH ARCELIOUS HOWARD, JR. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors' Community Hospital Lanham Prince Georges 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10 M 2□ F Days Hours Yrs. Director 231-01-5304 78 August 10, 1920 Norfolk, Virginia Usuai Rasidenca of Decedant 10a State 10b County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1X Yas 2 □ No Directo Maryland Prince Georges Lanham 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 10306 Diablo Avenue 20706 U.S.A. Funeral 12. Was Decedant Evar in U.S. Armad Forcas? 12/42 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 12/45 11. Marifal Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black. Whita, atc. 1 Nevar Married 2K Married 1 Yas 2 No Specify: Be Completed by Specify: 3 Widowad 4 Divorced Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacadant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elemantary/Secondery (0-12) College (1-4or 5+) 12th Automation Mechanic Government permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygie Important: if Nem 27 ia merked other 1 any Injury or other traumatic event, III 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Surnema) Noah Arcelious Howard, Sr. 0 Susie Carr 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Marjorie R. Howard/Wife 10306 Diablo Avenue, Lanham, Maryland 20706 20b. Place of Disposition (Nama of cometery, cramatory or other place) 20a. Method of Disposition 04/09 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Maryland National Mem. Park 1999 Laurel, Maryland 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility
J.B. JENKINS FUNERAL HOME ten 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 0 23a. Part1. Enfar tha disease, or complications that caused the death. Do not anfar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallura. List only one cause on each line. Approximate Interval Batween **Physician** /Medical Immediata Causa (Final disaesa or condition rasuiting in daath) Examiner Dua Examiner The lew requires that the death certificate be axecuted use as the burief-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated seasa or Injury Dua to (or as a consequence of) Box 68760. Physician/Medicai that initieted evants rasulting in daath) Lasf Dua fo (or as a consaguanca of): for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 1 Yes 2 No 3 Probably 4 Inknown GAMORAL Records, ð page 2 should be Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? has cartificate 1 ☐ Yas 2 ☐ No Division of Vital Physician: Be 25. Was casa rafarred to medical axaminar? 26. Piece of Daath (Check only ona) 22€R/Outpatient 3□ DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 Yas 1 Inpatiant this 27. Mannar of Death Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 2 Accident or Attending 5 Pending Investigation s after death. 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 T Homleida To the Hospital c within 24 hours at To the Funerat D Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifiar Medicai (Check III one 29b. Signatura titled certifie CHARD FELDMAN 29c. Licansa number 29d, Data signed (Month, Day, Year) 30 Nama and address of person w emplated causa of daath (itam 23a) (Type, Print) (when um do 106 9200 200 32 Ragistrar's Signetura State Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 12125

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** MARCH 27, 1999 2:39 pm HOLLOWAY G. VIVIAN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 6 Sax **Funeral** 1□ M 2MF Months 9-06-1924 VA. Director ROANOKE, 215-24-6379 the Manylend 10a State 10b County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Examiner must be notified at 1 Yas 2 No MD PRINCE GEORGES BELTSVILLE Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 20705 U.S.A. 11346 CHERRY HILL RD., #201 deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. filed within 72 hours ofter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING HOUSE OF REP. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) if and 2 should be fill Heelth and Mentel H lem 27 fs marked oth Be WATTS RICE PATRICK LAURA 2 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 20705 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 nent of Heelth a nt: If Item 27 fs #201 BELTSVILLE, MD DON HOLLOWAY - HUSBAND 11346 CHERRY HILL RD., Baltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stafa 20a. Mathod of Disposition Date 4 1 ☐ Burial 2 TCramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Depertment of Important: If Imp Injury or CHESAPEAKE CREMATORY 8-99 BELTSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
TAYLOR 'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that dused the shock, or heart failure. List only one cause of each line ed the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS Examiner Due to (or as a consequence of): Examiner END STAGE RENAL FAILURE physician end the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. DIABETES MELLITUS edical Due to (or as a consequence of): 82 Physician/M esn ō 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other algorificant conditions confributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown CHF signed I Records, P 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy completion of ceuse of deeth? pege 2 1 ☐ Yes M☐ No certificate 1 ☐ Yes 250 No of Vital Hospital or Attending Physician: director 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Division 5 Pending investigation 1 Natural Injury s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, straef, factory, office building, atc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the tima, data and place, end due to the ceuse(s) and mannar as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D25640 APRIL 8, 1999 201

Registrar

State

31. Date filed (Month, Day, Year) APR 0 8 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Eugene Harris APRIL 03, 1999 2:24 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner CAMP SPRINGS
If Under 1 Year | If Under 24 Hrs. | 8, Date MALCOLM GROW MEDICAL CENTER PRINCE GEORGE'S 5. Social Sacurity Number 6. Sax 12 M 2□ F 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days Min Months Hours Yrs. 417-48-3245 61 1937 **Director** Alabama Usual Rasidance of Dacedani 10a Stata 10h Counts 10c. City, Town or Location 10d. fnsida City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinat must be notified at 1 XYas 2 No Director Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2600 Porter Avenue 20746 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 (X) Yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Raca - American Indian, 11 Marital Status 1 ☐ Navar Marriad 2 X Married African 1 Yas 2 XNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 12th Computer Operations Government - Military 17. Fathar's Nama (First. Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Jim Harris Laura Kennedy 2 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Nama/Ratationship (Type, Print) 2600 Porter Ave., Suitland, MD 20746 Renee Harris - Wife 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Washington National Cem 4/9/99 Suitland, MD 21. Signatura of Funaral Sarvice Licensea 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 My 23a Part Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) MASSIVE MYOCARDIAL INFARCTION 30 MINUTES Examiner Dua to (or as a consaquence of): Examiner DYSRYTHMIA Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Diseese or injury that initieted avants rasulting in daath) Last Dua to (or as a consequance of): LIKELY CORONARY ARTERY DISEASE Physician/Medical Dua to (or as a consequance of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown A 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of death? 1 ☐ Yas 2 🗓 No 1 TYAS AT NO 25. Wes cesa rafarred to medical 26. Place of Death (Check only ona) Be Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1X Yas 2 No 2 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 27. Mennar of Death Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 Yas 2 No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of fnjury - At homa, farm, streat, factory, office building, etc. (Specify) 4 D Homleide 1 Cartifying Phyalcfan: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mennar as stated.

| Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical (Check only one) 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) DE C1000495 APRIL 03, 1999 30. Name and address of person 9 completed cause of death (Item 23a) (Type, Print) MARY F. HART, MAJ, USAF, MC

State Registrar 31. Data filad (Month, Day, Year) APR 0 5 1999 32. Ragistrar's Signatura frank

DHMH 16 Bay 6/95

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death

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Peges 1 and 2 should be frant of Haaith and Mental I int: if Item 27 is marked of

Department of Health mportant: If Item 27

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Hospital or Al 24 hours after

To the Hospital within 24 hours a To the Funeral C

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physician

Baltimore, Maryland 21215-0020

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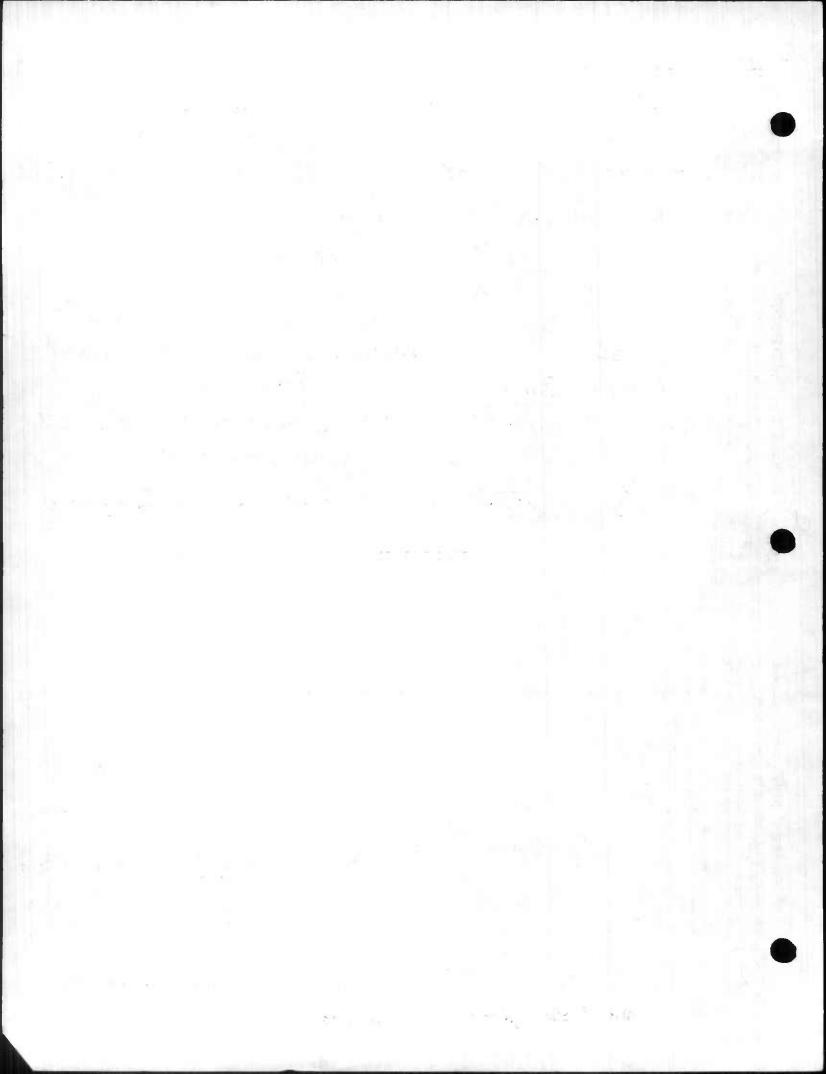
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| artment of Health and Menta | l Hygiene | 121 |
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| Dhuaisian | 1. Decedent's Name (First, Midd | le, Last) | | | | | | Dete of Deet Month | h Dey | 3. Time of De | |
| Physician /Medical | Mark John | Henderson | | III. | | | | ARCH | 31, 19 | | |
| Examiner | 4e Facility Name (If not institution 8040 13TH ST | | nber) | | | | wn, or Locatio ER SPR | | 4c. County MONT | of Death GOMERY | |
| Funeral | 5. Social Security Number | | 7. Age (In yrs. I | ast birthday) | If Under 1 Year Months Days | If Under 2 | | Dete of Birth Month, Dey, | Year | Birthplace (State or Fi Country) | |
| Director | 479-90-3161 | 13KJM 2□F | 30 | Yrs. | Months Days | Hours | | | | Vashington, | |
| 2 | Usual Residence of Decedent 10s. State 10b. County | | 10. 0 | Town and | | | | | | 1011-11-05-1 | |
| aryta and and and and and and and and and an | Tou. State | | Toc. Oity | , Town or L | Callon | | | | | 10d. Inside City L | |
| or that a | DC | | Wasl | hingto | | | | | 0.22 | | |
| | 10e. Street and Number | | | | 10f. Zip Code | | | 10 | og. Citizen of V | vnat Country? | |
| oral mast | 516 Hamilton | | dent Ever in U.S | 6 112 | 2001 | | ning (Canaih) | Van er No | | USA 14. Rece - American Indien, | |
| hours after death unal, or hams 23 al Examinar must d by Funeral | 11. Marital Status 1☑Never Married 2☐ Mer 3☐ Widowed 4☐ Divorced | Armed For ned 1 ☐ Yes If Yes, Give | ces? 2[] No | 3. 13. | Wes Decedent of H If Yes, specify Cubin 1 ☐ Yes 2X No | an, Mexican | , Puerto Ricar | | | | |
| 2 ahout be fled within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Examp To Be Completed by F | | nt's Education | 16a. Decedent's Usual Occupetion | | | etion | | | 16b. Kind of Bu | siness/Industry | |
| ed within 72 hay yplene. wer than "natur n, the Medical. Completed | (Specify only highe | st grade completed) | | (Give kind of work done during most of working to the life. DO NOT use retired) | | | of working | | | and the same of th | |
| the set of | Elementary/Secondary (0-12) | College (1- | 40r 5+) | Unemployed | | | | | Non | ne | |
| Be C | 17. Father's Name (First, Middle, | Last) | | 18. Mother's Neme | | | r's Neme (Fire | st, Middle, N | leiden Sumem | (e) | |
| Mental Me | John Spiller | vler. Jr. | | | Diane Ro | | | elle H | enderso | on | |
| M M M | 19a. Informant's Neme/Relations | | | 19b. Maili | ng Address (Street | | | | | | |
| 77. Trans | Catherine You | ing/Grandmo | other | 516 F | lamilton | St. NE | . Wash | ingto | n,DC 20 | 0011 | |
| offine and a | 20a. Method of Disposition | ing/oraname | 20b. Pl | ece of Dispo | osition (Neme of metory or other ple | | | | | City or Town, Stete | |
| wirmit. Pages 1 a Department of He mportant: if them iny injury or other office. | 1 Burial 2 Cremetion 4 Donetion 5 Other (5 | | tete . | | Memorial | | 4-6- | .99 | Suitlar | d. MD. | |
| in parties of | 21. Signature of Fugeral Service | | | 2 | 2. Name end Addre | ss of Facility | v - | | | id, IID. | |
| E de la constante de la consta | 1 0 mb | 1000 | 7 | | Name end Addre | | | | | | |
| - | 23a Parti. Enter the disease, o | anace | was all this also all | | 217 9th | | | | | .C. 20011 | |
| cete be executed physician and it the buriel-transit clical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. <u>S</u> | | as e consec | | | | | | | |
| | | d | | | | | | | | - 182 | |
| deeth deeth ed for e | Part II. Other algnificant condition | ons contributing to dec | ath but not resu | Iting in the u | inderlying cause giv | ren in Pert I. | | 23b. Did to | bacco usa poi | ntribute to the cause of c | |
| > | | | | | | | | 1 🗆 Ye | 2 No | 3 Probably 4 Un | |
| The law requires the hest been sign, page 2 should be | | | | | | | | 24a. Was er pertorn | | 24b. Were autopsy find available prior to completion of caus of death? | |
| he lew requir he hes been sign 2 should ompleted | | | | | | | | / | | | |
| Faa | | | | | | | | 1 2 Ye | s 2 No | 1 ☐ Yes 2 ☐ No | |
| Physicien: The certificate rail director, per TO Be Co | 25. Was case referred to medica examiner? | Hospital: | | | 04 | 100 | of Deeth (Ch | | | | |
| | XIX Yes 2 No 27. Manner of Death | 1 1 10 | | | nt 3 DOA Oth | 4LI NU | | | | er (Specify) AT SC | |
| or Attending of Attendesh. Sirector: After In by the fune ortification | 1 Natural 5 Pendia 2 Accident Investi 3 Suicide 6 Could 4 Homicide determ | gation not be nined 28e. Place o buildin | 199 | | Wo | Yes 211 | No 50 | ubje | reet end Numb | ot by po er or Aural Addie Number Spring M | |
| To the Hospital within 24 hours Completely filled | 29a. Certifier (Check only one) 1 Certifyir 2 Medical | ng Physician: To the b | pest of my know sis of examineti | viedge, deat ion and/or in | h occurred at the tir vestigation, in my o | ne, date end | d place, end d | due to the ce the time, da | puse(s) and me ate and plece, | onner es state and due to the ceuse(s) | |
| To the within comp | 29b. Signature and title of certifie | aner V | M.D. | 29c. License number 29d. Date signed (Mor O.C.M.E MARCH 31 | | | | | | | |
| 4 | 30. Name and address of person | Restane | | ll Pen | Print) in Street, | , Balt | imore, | Mary. | land 21 | .201 | |

geer , e i.i. The state of the s

| ert Curtis ITEMS: #23 | PART I, 27, 28A-F PER | | 0 | nt of Health and te of Death | Be | ng. No. | 131 | 39 |
|--|--|---|------------------------|--|--|---------------------|------------------------|--|
| Physician | 1. Decedent's Neme (First, Middle, La. | Cartis 6 | farri: | 5 | 2. Dete of Deat Month April 1 | h Беу 5, 1999 | Year | Tima of Death : 40 A.M. |
| /Medical Examiner | 4a Facility Name (If not institution, give | | | | Location of Death | 4c. County | | |
| 20 | 523 Kirby Parkway | | as binstand If Line | Fort Wa | shington 8. Date of Birth | | ce Georg | |
| Funeral Director | 5. Social Security Number 6. S 414 - 76 - 608 1 | 9X 7. Age (In yrs. Ia 10 M 2□ F 45 | Yrs. Month | | | Year) , 1953 | Country) | ille TN |
| P & E | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Location | | | / | 10d. Ir | nside City Limits |
| the Marylar 28a-1 show notified at | TN Willia | IM F | RINKI | in | | | 1, | Yes 2□No |
| \$ 9 B | 10e. Street and Number | D. 10. 1 | 10f. 2 | Tip Code | 7 | Og. Citizen of \ | What Country? | |
| of the country of the | 1 5 8 1519 L 11. Marital Status | 12. Wes Decedent Ever in U,S Armed Forces? | . 13. Was Dec | edent of Hispanic Origin? (ecify Cuban, Mexican, Pue | Specify Yes or No- | | a - American In | dien, |
| Urs of | 1 Never Merried 20 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Detes: | 1 ☐ Yes | ./ | no rican, etc.) | Specify | ck, White, etc. $Blac$ | -11 |
| 1 21215-0020 ed within 72 hours et Vgiene. You then "natural", or nt, the Medical Example Completed by F | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16a. Decedent's Us | vork done during most of w | | 16b. Kind of B | usiness/Industry | ' ' |
| 212 d within | Elementary/Secondary (0-12) | College (1-4or 5+) | Musi | . '/) / | OR | Ente | ertaini | mont |
| | 17. Father's Name (First, Middle, Last) | 2 45 | | 18. Mother's Na | ame (First, Middle, A | Maiden Sumen | ne) | |
| Maryland d 2 should be file d 2 should be file h and Mental Hy 71a marked other treumatic event | 19a. Informant's Neme/Relationship | Type, Print) | 19b. Mailing Addre | ss (Street and Number or F | Rural Route Number | City or Town, | Stete, Zip Code | 9) |
| C = 01 b | Karen Harri | s/wite | 138 B | ig BeN C | st. Fran | Klin | TN 37 | 067 |
| altimore, mil. Pages 1 an partment of Heal portant: if Item 2 y Injury or other 55. | 20a. Method of Disposition 1 Burial 2 Cremation 3 | Removel from State | netery, cremetory o | other plece) | Date : | Nash | City or Town, S | Stete |
| Baltin pemit. Pe Department Important eny injury pncs. | □ Donation 5 □ Other (Specification of Funeral Service Licenses) | | 22. Name | end Address of Fecility | STRICKI | ANA | Fulleral | Succ |
| Balt Permit. Departiment Importing eny in | 1 Chield | the kleus | 6500 | Allentow | n Po. Co | mos | Dringis | KIN |
| Physician /Medical Examiner | Immediate Cause (Finel disease, or come hook or heart failure. List only immediate Cause (Finel disease or condition resulting in death) | one cause on each line. NARCOTIC IN | | | | | Inter | roximete rvel Between et and Deeth |
| oxecuted in and intransit | Sequentially list conditions | b. Due to (or | es e consequence o | n): | | | 1 | |
| 8760, rate be executed shysician and the burial-transit dical Examir | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C | | | | | | |
| ficate ficate physics the | that initieted events resulting in death) Last | Due to (or e | es a consequence o |): | | | | |
| m the store | Part II. Other significant conditions o | ontributing to death but not result | ing in the underlying | cause given in Pert I. | 23b. Dtd to | bacco use co | ntribute to the | cause of death? |
| C X 70 | | | | | 1□ Y | 8 2□No | 3 Probably | 4 ☐ Unknow |
| cords requires been sign should be | | | | | 24a. Was a perform | n autopsy ned? | availabl | utopsy findings e prior to tion of cause 1? |
| The lay | | | | | 16 Ye | s 2□No | D Yes | s 2□ No |
| Vital I biclen: The certificate irector, page O Be Co | 25. Was case referred to medical examiner? 1% Yes 2 No | Hospital: | D/O 44-15-14 000 | Othor | eath (Check only on | | (0 | |
| on of V ding Physic h. After this o funeral dire | 27. Manner of Death | 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | Home 5 Reside | | | scene . |
| Division or Attending effector: After d in by the fune ertification | 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 X Could not be | 4-15-99 | JNKNOWN M | 1 ☐ Yes 2 ☑ No | UNKNOWN | | 2 10 10 | A- A44 |
| Division of To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification: | 4 Homicide determined | 28e. Place of Injury - At hom building, etc. (Specify) HOUSE | ne, larm, street, fact | ory, office | 28f. Location (St City or Town WASHINGTO | , State) 52: | 3 KIRBY P | KWY., FOR |
| Ne Hospital n 24 hours ne Funeral pletely filled | | yeiclan: To the best of my knowl iner: On the basis of examination and manner steted. | | | | | | |
| To the To the comple | 29b. Signature and title of certifier | C C C C C C C C C C C C C C C C C C C | 2 | 9c. License number | 2 | | d (Month, Day, | |
| | 1 larah | Kenno | | O.C.M.E. | | April | 15, 199 | 99 |
| (2) | 30. Name and address of person who | completed cause of death (Item 2 | | Penn Street, | Baltimor | e, Mary | vland 2 | 1201 |
| State Registrar | 31. Date filed (Month, Day, Year) APR 1 9 199 | 32. Registrar's Signetu | 1-1 | 4 | | | | 7-11 |



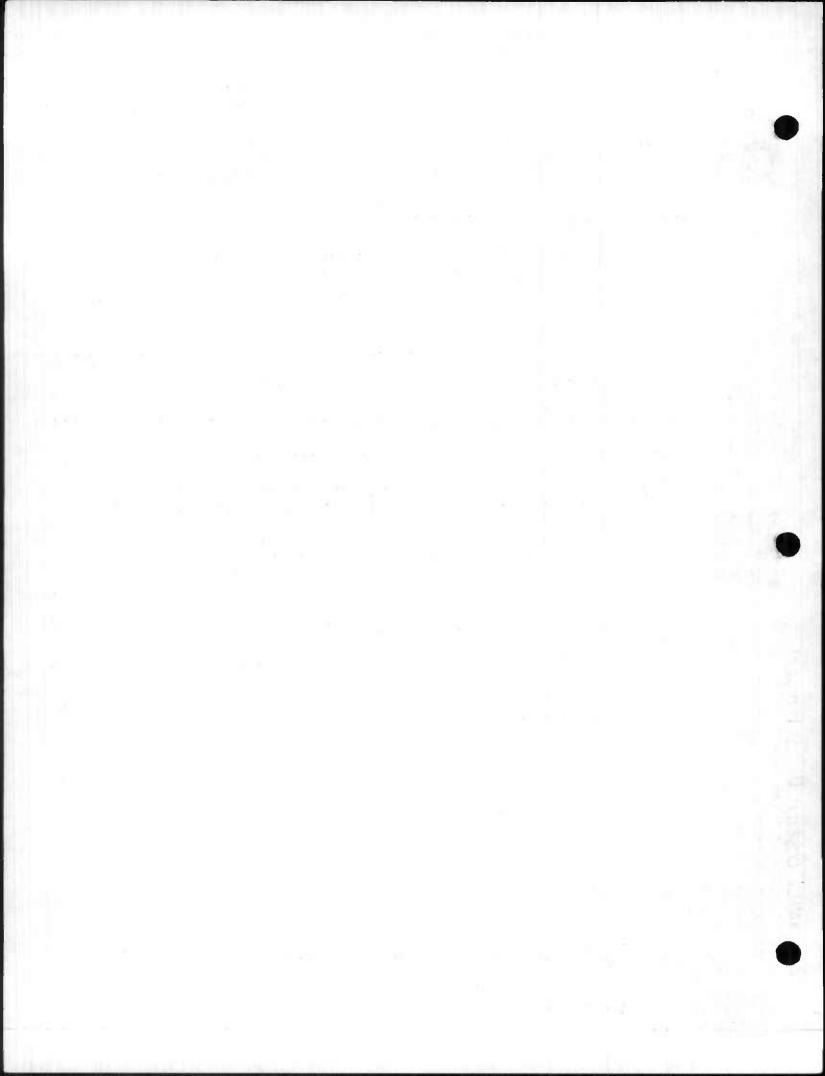
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** March 29 1999 2025 OSCAR W. JOHNSON /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore 54 Healthcare Agnes NONE 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** 10XM 2□ F Deys Hours Yrs. Director 216-18-5155 80 MARCH 23 1919 MARYLAND Usuel Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director No Yes 2 No MARYLAND NONE BALTIMORE 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3 S. ROSEDALE STREET 21229 US death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after of neat of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ites my or other traumatic event, the Medical Examiner my or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 21215-0020 1 ☐ Yes XXNo Specify: Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th LABORER KAVANAUGH COMPANY Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be ALFRED JOHNSON NANCY HARRIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) VIOLA GROSS (DAUGHTER) 614 SEVERN ISLAND CT. ANNAPOLIS, MD. 21401 20e. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) pemit. Pege Depertment or Important: If any Injury or once. CEDAR HILL CEMETERY 4/5/99 BALTIMORE, MD. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, and a 21401 Approximate Interval Between Onset and Deeth Onset and Deeth **Physician** /Medical Immediete Ceuse (Final · mutisystem Organ failure disease or condition resulting in deeth) Days **Examiner** Due to (or es e consequence of): Examiner weck Sertic Shock ettending physician end for use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) requires that the death certificate be execu NAME: OSear W・Johnson Division of Vital Records, P.O. Box 68760. Infection Abdominal Physician/Medicai Due to (or es a consequence of): 98 Subtotal Colectomy Post a. Status weeks Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 WUnknown Myocardial Infarction 24b. Were autopsy findings evalleble prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? page 2 s 1 ☐ Yes 2 🗷 No this certificate 1 ☐ Yes 2 No Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☑Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation 1 Neturel deeth. 1 ☐ Yes 2 ☐ No eral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) after a 4 Homicide hours Funeral edical (1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) P10878 MARCH 29 Resident Deportment of 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Par Year) 1000 | 32. Régistrer's Signeture 14. Bultimore maryland 21229 Cuton Avenue 31. Dete filed (Month, Dey, Year) APR 0 5 1999 State

DHMH 16 Bay 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FArman 1:05 PM 1999 April 3 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Westminster NUrsing Westminster Home If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2FC F Months Days 148-10-0911 Yrs. March 25, 1907 MAryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Westminster Maryland 1 Yes 2 No CArroll 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? St Charles 32 21157 USA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marifal Status 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 KNo Specify: Black 3 Widowed 4 □ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Astor Bethel A.M.E. Ch 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JAMES E Cornish OCKIMAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cornish Sr. (Brother) 32 Charles St. Westminster MD 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Richards Memorial Park 4/10/99 22. Name and Address of Facility Pritts Funeral Home + Chapel. 21. Signeture of Funeral Servica Licansee 412 Washington De Wastminster 21157 23a. Part 1 Where the disease, or complication It sed the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one cars in schiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) CVD Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death buf not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medicai **Examiner**

The lew requires that the death certificets be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funerai

Director

28a-f show

or Items 23a or

"natural".

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permit. Pagas 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i

Director

Funeral

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Be Completed

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traumetic event, the Medical Examiner must be notified at

filled within 72 hours after deeth with the Maryland

altimore, Maryland 21215-0020

Physician/Medical Examiner bunal-tran attending physician for use as the burial signed by the aid be datached for Completed pege 2 s funaral director, Be Certification: To To the Hospital or Attending Phys within 24 hours effer death.

To the Funeral Director: Affar this complately filled in by tha funaral di

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cartificate has

or Attending Physician:

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Medical

| | | 1 Yee 2 No 3 Probably 4 Unknow |
|---|--|---|
| | | 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? |
| | | 1 Yes 2 No 1 Yes 2 No |
| 25. Was cese referred to medical examiner? | 26. Place of Death (| Check only one) |
| 1 Yes 2 Vo | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home | |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28c. Work? | d. Describe how Injury occurred |
| 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At home, farm, streef, factory, offica building, etc. (Specify) | . Location (Street end Number or Rurel Route Number, City or Town, Stete) |
| 29a. Certifier 1 Cartifying Ph | yelclan: To the best of my knowledge, death occurred at the time, date and place, and illner: On the basis of examination end/or investigation, in my opinion, death occurred and menor state. | due to the ceuse(s) and manner as stated. at the time, date and place, and due to the ceuse(s) |

State Registrar 31. Date file (Wonth, Day, Year)

APR 0

29b. SignaAure and title of certifier

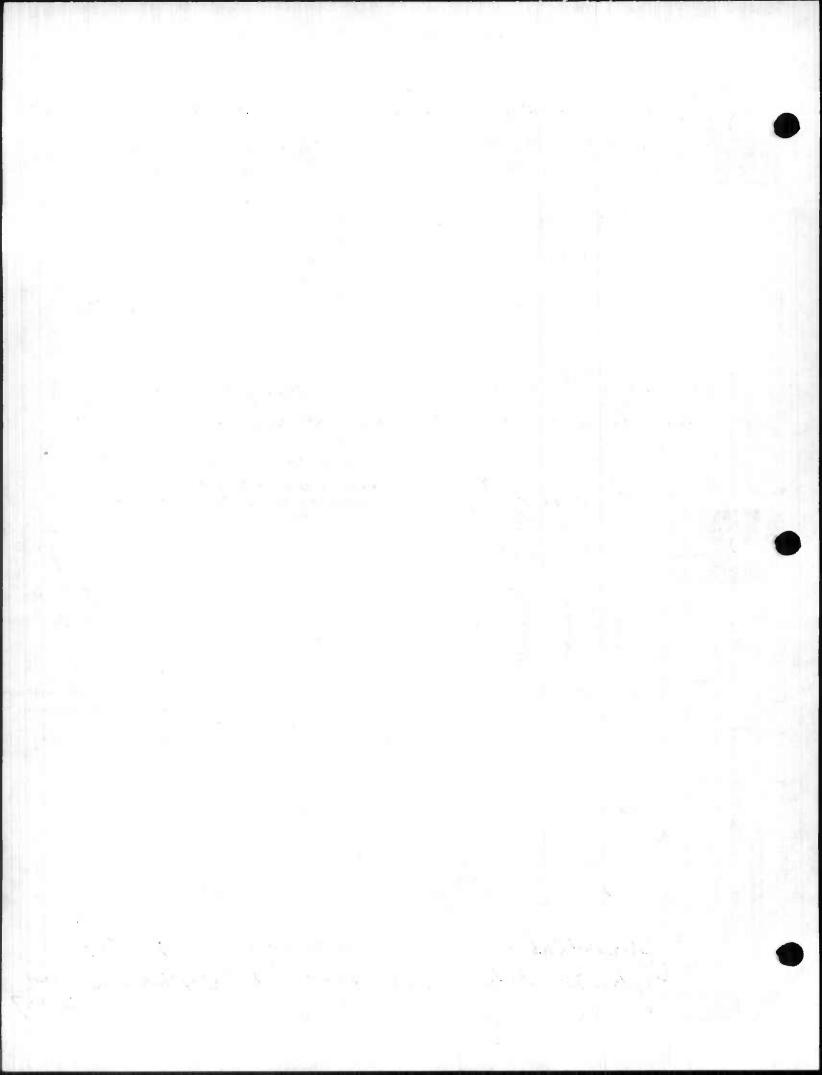
delet

32. Registrar's Signeture

nd address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year)



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ALBERT CLASTER JONES 1:00AM 1, 1999 APRIL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FT. WASHINGTON HOSPITAL FT. WASHINGTON If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1☐M 2□ F Days Yrs. 1923 Danville, Va 76 January 4, Director 577-26-2760 Usual Residence of Deceden with the Manyland 10d Inside City Limits 10a State 10h Counts 10c. City. Town or Location "natural", or items 23a or 28a-f show afficial Examiner must be notified at 1□ Yes 2□ No Maryland Prince George's Ft. Washington Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 USA 8908 DORIS DRIVE e filed within 72 hours efter death wish Hygiene.
other than "netural", or items 23a vent, the Medical Examinat must be Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces?

\$☐ Yes 2☐ NoUSAF If Yes, Give 14. Reca - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK P 3 XWidowed 4 ☐ Divorced Year or Dates 941-1943 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE TRUCK DRIVER 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be family of Heelth end Mentel I in: If item 27 is marked of MARY PEARL ADAMS ELBERT C. JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8908 DORIS DRIVE FT. WASHINGTON, MD 20744 ANTOINETTE JONES BLACK or other 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or pace. Lincoln Memorial Cemetery 4-7-99 Suitland, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of Md 21. Signature of Funeral Servica Licenses Suitland, MD 4308 Suitland Rd. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final SEPTIC SHOCK disease or condition **Examiner** Due to (or as a consequence of): Examiner ACUTE RESPIRATORY ARREST physicien end s the burial-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SEVERE METABOLIC ACIDOSIS Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequenca of) 98 for use es signed by the elid be detached for Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of ceath? 1 Yss 2 No 3 Probably 4 Vunknown HYPOTENSION SHOCK by 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Was an autopsy Completed peeu CVA ils certificete hes il director, page 2 s The 1 ☐ Yes 2 No 1 Yes X No S/P INTUBATION Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 25 No N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aff Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) April 6, 1999 Doo26715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20032 1328 SOUTHERN AVE. #207 WASHNGTON, DC DR. HAFIZI

32 Registrar's Signature

Sports

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 7 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| Citati | | | | ment of Health and I ficate of Death | | giene 99 | 13143 |
|---------------------|---|----------------|--|---|--|---|---|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last) Ella Johnson | | 2. Data of De Month | Day 14 4 | 3. Time of Death 7:544w |
| 7 | Exami | ner | 4a. Fscility Name (If not institution, give street and number) Holy Cross Hospital | | Location of Death | Montgo | omery |
| L | Funeral Director | | | f Undar 1 Year If Under 24 Hrs. Ionths Deys Hours Min. | | | rthpiece (State or Foraign country) rginia |
| | Maryland 4 show | or | 10e. Steta 10b. County 10c. City, Town or Locati Maryland Montgomery Silv | er Spring | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | death with the Maryland ms 23a or 28s-f show ma 1 be nouried | Director | 10e. Street and Number | 10f. Zip Code | | 10g. Citizen of Whet C | 21 |
| 020 | or he | by Funeral | 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ No | 20904 s Decadent of Hispenic Origin? (S es, specify Cuban, Mexican, Puart Yes 25 No Specify: | pecify Yes or No o Rican, etc.) | United 14. Reca - Am Bleck, Wh Specify: B1 | erican Indien, ite, etc. |
| Maryland 21215-0020 | | Completed | Elementary/Secondery (0-12) College (1-4or 5+) | t's Usual Occupation d of work done during most of wor NOT use retired) USINESS OWNER | rking | 16b. Kind of Business | |
| and 2 | d be filed antal Hygi and other c event, t | Be | 17. Father's Name (First, Middle, Last) Rueben Walker | 18. Mother's Ner | me <i>(First, Middi</i> e, nnie Wal | Maiden Sumame) | |
| Mary | d 2 shoul th and Me 7 le mark traumeti | To | 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing A | Address (Street and Number or Au - 17th Place, N | urai Routa Numbe | er, City or Town, State, | |
| Baltimore, | permit. Pegas 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 le marked other than "any injury or other traumatic event, the Means. | | 20a. Method of Disposition 1 Buriel 2 Cremation 3 Ramoval from Stata 20b. Place of Disposition cemetery, cremator | on (Neme of ory or other place) | Dete | 20c. Location - City o | r Town, State |
| Ball | Departme Departme Importan any Injur- | | 21. Signature of Funeral Service Licensee 22. No | ame end Address of Fecility | | Suitlan Funeral Ho | me |
| | Physician | | 23a. Part 1. Effair the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. | Ol Benning Rd., he mode of dying, such as cardiac | N.E. Wa | rest, | Approximata Intervei Between Onsat and Death |
| | /Medical Examiner | | Immediate Ceuse (Final disease or condition resulting in death) a. Aftersole extra | | D: seose | | 1990 |
| - | nsit | Examiner | Due to (or es a consequer | | | | 1990 |
| 60, | icata be axecuted physician and s tha burial-transit | al Exa | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Diseasa or injury | ^ | L | | 1990 |
| Box 68760, | nding physics of the less of the less of the less of the less the less of the | n/Medical | that initiated events resulting in death) Last Dua to (or as a consequent problem of the consequence prob | | | | 1440 |
| P.O. B | thet the daath cartif ed by tha attanding detached for usa e | Physician/M | Part II. Other significant conditions contributing to death but not resulting in the under | rlying cause given in Pert I. | | | le to the cause of death? |
| | w requiras thet been signed b should be deta | b | | | | | Probably 4 Unknown |
| of Vital Records, | @ S C | Completed | | | 24e. Wes perio | an eutopsy 24b rmed? | . Were autopsy findings available prior to completion of cause of death? |
| ital | | Be Col | 25. Wes case referred to medical | 28. Place of Dec | 1 □) eth (Check only o | | 1 ☐ Yes 28 No |
| of V | Physician: this cartific ral director, | ဥ | examiner? 1 Yes 2 No Hospital: 1 Inpatiant 2 ER/Outpatient : 27. Manner of Death 28e. Date of Injury 28b. Time of | 3□ DOA Other: 4□ Nursing H | iome 5 ☐ Resid | dence 6 Other (Sp. | ecify) |
| ion | Attending I or daath. ector: Aftar by the funer | ation | 1 Maturel 5 Pending (Month, Day Year) injury | 28c. injury at Work? M 1 Yes 2 No | A L | now injury occurred | |
| Division | 7 4 4 5 | Certification: | 3 Sulcide 6 Could not be determined 28a. Placa of injury - At homa, farm, street, building, etc. (Specify) | | City or Tox | | |
| | To the Hospital of within 24 hours a To the Funerel Complately filled | edical | 29a. Certifier (Check only one) 1页 Certifying Physician: To the best of my knowledge, death occurrence one) 1页 Certifying Physician: To the best of examinetion end/or invest end manner stated. | curred at the time, date end pleca igation, in my opinion, deeth occu | red et the time, | ceuse(s) and manner e dete and pleca, end du | es stated. le to the cause(s) |
| | To the To the Comp | X | 29b. Signature and title of certifiar B B Patrub II M | 29c. License number D (772 | | 29d. Dete signed (Mor | |
| | (10) | | 30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print B. B. P. + F. W. T. W. T. W. T. | lo ledville R | 2 d S | ilver Spri | Ji MD+0910 |
| | Sta Registr | | 31. Date flied (Month, Day, Yeer) APR 0 5 1999 | hart | | | |

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State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 1 1. [,

| | | | Cer | tificate of | Death | | Reg. No. | | i rê rê |
|---|--|---|---|--|---|--|---|--|-------------------------|
| Physiciar | TITCHAET DEL | | | | | 2. Dete of De Month April | | Year | ime of Death 35 PM |
| /Medica Examine | 4 - 40 - 1414 - 41 - 1 - 414 - 414 - 41 - 41 | | a | | 4b. City, Town, or I | _ | 4c. County | | |
| Funeral Director | 5. Social Security Number 6. Se | - | last birthday) | If Under 1 Yeer Months Days | If Under 24 Hrs. | 4. | , yeer 191 | _ | 4 |
| 2 * | Usual Residence of Decedent 10a. State 10b. County | 10c. G | ity, Town or Lo | cation | | | | · · · · · · · · · · · · · · · · · · · | Ide City Limits |
| Marylar e-f show filed at | | | | Spring | -, -, | | | | Yes 2 No |
| rer doubt with the Maryland thems 23s or 28s4 show the must be notified at | 10e. Street and Number 2445 Lyttonsvil | le Road | | 10f. Zip Code | 20910 | | 10g. Citizen of V USZ | | SEVE |
| ar, or | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in L Armed Forces? 1 Yes 25 No If Yes, Give 22 Year or Dates; | | Ves Decedent of I Yes, specify Cub | Hispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No o Rican, etc.) | 14. Rac Blac Specify | e - American Indi ck, White, etc. White | |
| od within 72 ho ygiera. ver than "natur it, the Medical. | 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) | | (Give I | ent's Usual Occup kind of work done OO NOT use retire let Mak | during most of word) | king | 16b. Kind of Business/Industry Giant Foods | | |
| Mental Hyg arked other affic event, | 17. Father's Name (First, Middle, Last) Louis Jewrekis | | | | | Name (First, Middle, Maiden Sumame) / (Unknown) | | | |
| 2 sho t and h is ma | 19a. Informant's Name/Relationship (T) | | | | | | | | |
| 1 and Health em 27 Ather 1 | Ann Jersky/Wi | 20b. Place of Disposition (Name of | | | | Rd., Si | | Spring, City or Town, Sta | |
| Pages nent of ant: If Its arry or o | 1 ∃ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | 1emovel from State | | anon Ce | metery | | | ohi, MD | |
| permit. Departm Importa eny inju | 21. Signature of Funeral Service Licens | | St | Name and Addre | ass of Facility brew Men | morial | Funera | al Home | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | b | Cantor as a consequence or as a consequence | | | | | | |
| certificate be associted adming physician and use as the burial-transit | | c | or as a consequ | | | | | | |
| of the death ceres of by the attendir | Pert II. Other significant conditions cor | ntributing to death but not res | sulting in the un | derlying cause gi | ven in Part I. | 23b. Did | obacco use co | ntribute to the ca | auge of death? |
| | | | | | | 10 | Yes 25 No | 3 Probably | 4 Unknown |
| The law requires that the death cerate has been signed by the attendir page 2 should be detached for use Completed by PhysicianA | | | | | | | an autopsy med? | 24b. Were aut available completic of death? | prior to on of cause |
| iclen: The law requires to certificate has been signe rector, page 2 should be to Be Completed by | 25. Was case reterred to medicat | | | | | 101 | | 1 🗆 Yes | 2 No |
| yalclan is certifi director | 1 TYes 20 No | lospital: | ER/Outpatient | 3□ DOA Oti | her: | ath <i>(Check only c</i> lome 5 ☐ Resid | | er (Specify) | |
| 는 돈을 | | 28a. Date of Injury (Month, Day Year) | 28b. Time of tnjury | 28c. tnju Wo | | | now injury occur | | |
| To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After completely filled in by the funeral Medical Certification: | | 28e. Place of Injury - At h building, etc. (Speci | | et, tactory, office | | 28f. Location (S City or Tox | | per or Rural Route |) Number, |
| he Hospi in 24 hou he Funer pletely fill | 29a. Certifier (Check only one) Certifying Physical Examination (Check only one) | nician: To the best of my knot ner: On the basis of examina and manner stated. | | | | | | | iuse(s) |
| To the To the Common | Deamo to | On 9 | Mr | 29c. Licens | 4032 | | 4/4 | Month, Day, Y | ear) |
| | 30. Name and address of person who co | | | ARRAGO | IT AVE, | KENS | INGTON | 1 MD a | 20875 |
| State | 31. Date tiled (Month, Day, Year) | 32. Registrar's Signa | ature | 4 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death April 1, 1999 **Physician** Katie Thelma Johnson 9:30 P.M. /Medical 4b. City, Town, or Location of Death Cheverly 4a Facility Nama (If not institution, giva street and number) Prince George's Examiner Prince George's Hospital Center 7. Aga (In yrs. last birthday) | If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Dev. Yeer) March 22, 1923 9. Birthplaca (State or Foreign Country) South Carolina **Funeral** 1□ M 2♥ F 250-30-8531 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mentel Physiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat must be notified an page. 10c. City, Town or Location Washington 10d. fnside City Limits 10a. Stete 10b. County D.C. Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 4316 Alabama Avenue, S.E. Funeral 12. Was Decadent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Housing Industry College (1-4or 5+) Elementary/Secondary (0-12) Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) John Fullard, Sr. Mabel Chapman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) -Daughte 1469 Morris Road, S.E. Washington, D.C. 20020 ovaldine 20b. Place of Disposition (Neme of cametery, cremetory or other placa)

Forest Hills Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/10/99 Clinton, Maryland 21. Signature of Funeral Service Lightsee 22. Name and Address of Facility Services, Inc. 1722 North Capitol Street, N.W. Washington, D.C. 20001 Timore Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) 10 days Preumonia Examiner Due to (or as a consequence of): Examiner 10 days 100115 physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? RESPIRATION FAILURE 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed ANTENIOSCIZIONE CArdiorguniar Disease Consestive heart Failure Drabettes Mellitus II 1 ☐ Yes 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records, P.O. Box 68760 Division of Vital or Attending Physician: ofter deeth Director: To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by th

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) APR 0 5 1999

29b. Signature and title of cartifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

1852

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) DEVORE MD 4203

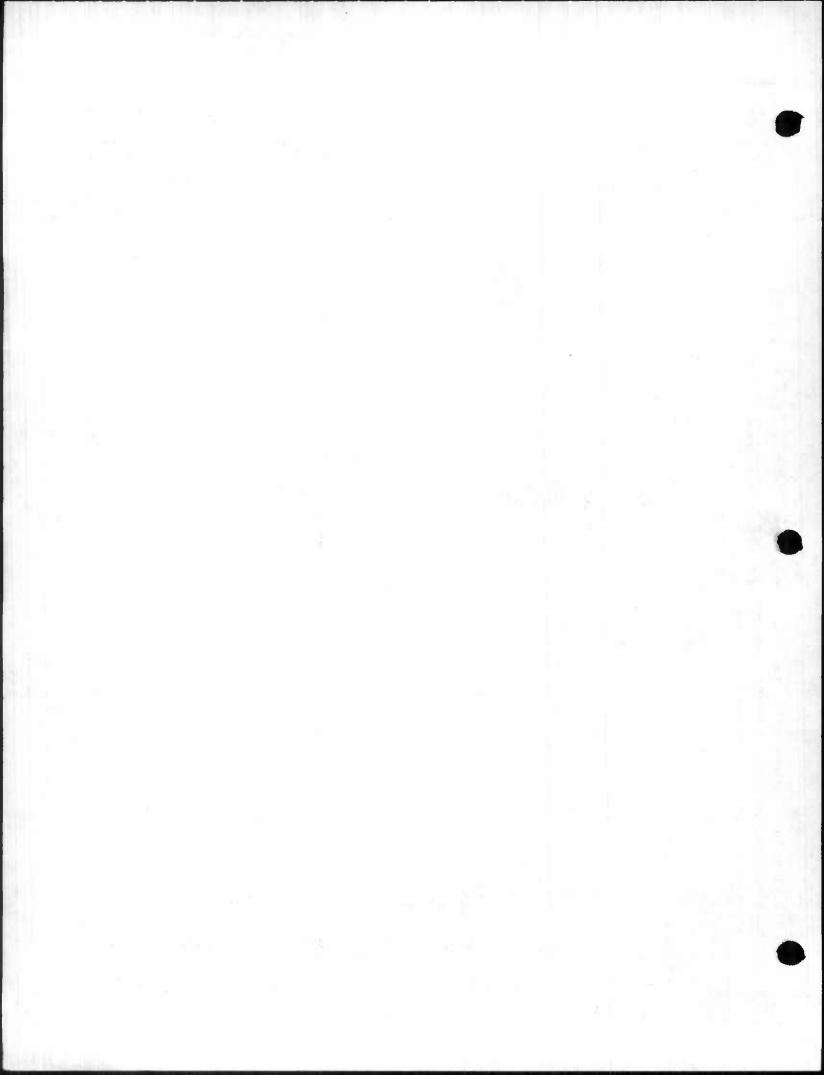
QUEENSPURY Rd HY ATTSUIL PMD 20781

32 Registrar's Signatura

Dec. 1999 See S. 1999

State of Maryland / Department of Health and Mental Hygiene

| | | | | | | , | | icate of | Death | | Reg. No. | | 5 40 |
|------------|--|------------------|--|---|--|-------------------------|----------------------------|--|--|---|-----------------------------------|----------------------------|--|
| | Physic /Medi | | 1. Decedent's Neme (First, Mid EVERETT CLAY' | | ISON | | | | | 2. Dete of De Month | Dey | Yeer 999 | 3. Time of Death 4:00 AM |
| | Exami | | 4e. Fecility Neme (If not instituti | on, give street end | d number) | | | | 4b. City, Town, or | | | | 4.00 AII |
| L | | ш | THE ALGONOUIN- 5. Social Security Number | | | (la la .4 b.) | 1 H | Under 1 Year | CUMBERLA If Under 24 Hrs | | | EGANY | |
| | Funeral Director | | 578-20-4158 | 6. Sex 1 X M 2□ | | (In yrs. lest bir 76 | | onths Deys | Hours Min | | | | lace (State or Foreign try) D.C. |
| | land ow | | Usual Residence of Decedent 10a. Stata 10b. Coun | у | 1 | 10c. City, Towr | or Location | en . | | | | 11 | Od. Inside City Limits |
| | Mary Fired | to | W.VA. MI | VERAL | | WILEY | FORD | | | | | | 1 ☐ Yes 2 ☑ No |
| | or 282 | Director | 10e. Street end Number | | | | 10 | Of. Zip Code | | | 10g. Citizan of | Whet Coun | itry? |
| 20 | 7.72 hours efter death with the Maryland "natural", or flems 23a or 28a-f show solical Examiner must be notified at | by Funeral D | RFD#1 BOX#53 | rried Armed | Decedent Ev d Forces? es 2 No , Give | | | 26767 Decedent of H s, specify Cub | dispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | | A. ce - Americ ck, White, | etc. |
| Ö | fural | | 3 XWidowed 4 Divorce | nt's Education | or Dates: WV | | Decedent's | Lleual Coour | potlon | | | | |
| 21215-0020 | filed within 72 he Hygiene. ther than "naturent, the Medical | Completed | (Specify only high Elementery/Secondary (0-12) | est grade complet | ed) ga (1-4or 5+) | | (Give kind lifa. DO N | of work done IOT use retire | petion during most of wo d) | rking | 16b. Kind of 8 | | |
| D | filed Hyg The | Be Co | 17. Fether's Neme (First, Middle | , Last) | | DA | KDEK | | 18. Mother's Ne | ma (First, Middle, | | | 3 |
| lar lar | Mental Mental arked o | To B | JAMES R. C. JO | HNSON | | | | | EVA M. | LEAMAN | | | |
| Maryland | d 2 should in and Men Y Is marked traumatic | | 19e. Informent's Neme/Relation | | | | | | end Number or R | | | | |
| | C = N - | | PATRICIA WAGONE | R | DAUGH | | | | RIDGE RO | AD, KNOXV | ILLE, I | TENN 3 | 37938 |
| Baltimore, | ages ant of t: If Ik y or o | | 20e. Method of Disposition 1 ☐ Burlal 2 🖾 Cremetion 4 ☐ Donetion 5 ☐ Other (| 3 ☐ Removei fro Specify) | om Stete | | y, cremetor | y or other ple | , | Dete 12 1999 | CUMBER | | wn, Stete MARYLAND |
| | Physician importan /Medical Examiner | | 23a. Perf 1. Enter the disease, shock, or heart feilure. List Immediate Cause (Finel disease or condition resulting in deeth) | er complications that only one cause of | Car | e deeth. Do n | 404 not enter the | DECATU e mode of dyin | AMS FUNE R STREET ng, such es cardia | CUMBERL c or respiretory ar | AND MAR | RYLAND | Approximete Interval Between Onset end Deeth |
| - | D # | Iner | | | Ca | line | | | | | | | 2 yre |
| x 68760, | ertificate be executed ling physician and re es the burlal-transit | Medical Examiner | Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest | c | | ue to (ores e c | | | | | | | |
| POX | death cer ne attendir ed for use | ian | | | | | | | | | | | |
| | thet the de ed by the detached | Physician/M | Pert II. Other significant condit | one contributing to | o death but r | not resulting In | the underly | ylng causa giv | en in Pert I. | 23b, Dld t | / | ntribute to | the cause of death? |
| ecords | aw requires is been sign 2 should be | Completed by | | | | | | | | 24e. Was o | en autopsy med? | con | ore autopsy findings allable prior to appletion of cause deeth? |
| = | The page | S | | | | | | | | 1 🗆 Y | es 2 No | 1 🗆 | Yes 2□ No |
| N I G | Physician: rthis certific ral director, | Be | 25. Wes case refarred to medic exeminer? | | | | | 045 | | ath (Check only o | ne) ASSIS | TED_L | IVING |
| 5 15 | After After fune | tion: To | 1 ☐ Yes 2 ☒ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpet | | | | | 28c. Injur Wor | y et k? | lome 5 Resid | - 41 | er (Specify red | 7) |
| DIVISION | To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At homa, ferm, str | | | | | | M 1 Yes 2 No | | | | l Route Number, |
| | ne Hospit n 24 hour ne Funera | edical (| 29e. Certifier 1 Certifyi (Check only one) 1 Certifyi | ng Physician: To Examiner: On the and m | the best of n a basis of ax nenner stetes | aminetion and | deeth occu /or invastig | urred et tha tin lation, in my o | ne, dete end plece pinion, death occu | o, end due to the d arred et tha tima, d | ause(s) end me lata and place, | enner as sta and dua to | ated. the ceuse(s) |
| | To the Comp | × | 29b. Signeture end title of pertific | or . | 1) | | | 29c. Licens | | 1 | 29d. Dete signe | d (Month, L | Dey, Year) |
| | 2 | | · | egelio | 1 00 | que " | yo, | D 1 | 3166 | A | PRIL 12 | , 199 | 9 |
| | nis | | 30. Name and eddrass of person DR. ANGEL H. | | | | | | CAL CENT | EB EDOCT | RIIDC M | ADVIA | ND |
| | Sta | te | 31. Date filed (Month, Dey, Year | | | Signeture | .TONII | THEDI | ONL CENT | rv tvo21 | DUKG, M | AKILA | מאוז |
| | Registr | | APR 13 % | .71 | The state of the s | fat. | The state of | the Best of | | | | | |



State of Maryland / Department of Health and Mental Hygierie

Certificate of Death

| Baltimore, Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours efter death with the |
|--------------------------------|--|
| Baltimore, | permit. Pages 1 and 2 should be filed |
| | Ph: /\ |

1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Yaer **Physician** JOHN DENNIS JACKSON APRIL 6, 1999 2205 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, giva straat end number) 4c. County of Deeth **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. lest birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Deys 18 M 2□ F Yrs 213-38-8520 Director 58 OCT 01,1940 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. Important: or Items 23s or 28s-f show important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examines must be notified at 1 Yes X No MARYLAND ALLEGANY FLINTSTONE Director 10f. Zip Code 10g. Citizan of Whet Country? 10e. Street and Number 10601 BLACK SULPHER ROAD 21530 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Dates: VIETNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Meritel Status 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: py 3 Widowed 4 Divorced WHITE 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PRISON CORRECTIONAL OFFICER 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ROBERT B. JACKSON MARGARET ANNAZ LEACH 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 10601 BLACK SULPHER RD FLINTSTONE, DONNA K. JACKSON/WIFE 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State APRIL 1 ☐ Buriat 2 Crametion 3 ☐ Removel from State SILBAUGH CREMATORY 8,1999 UNIONTOWN, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licenses 22. Name end Address of Fecility
HAFER CHAPEL OF THE HILLS MORTUARY any Ir las 23a. Pent1. Enter the discription or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failth. List only one cause on each line. 1302 NATIONAL HWY, LAVALE, MD 21502 Approximate interval Between Onset end Deeth vsician ledical Immediete Ceuse (Finel disease or condition resulting in deeth) Ika aminer Due to (or es a consequence of): Examiner an death certificate be executed physician and s the buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (orles e consequenca of): atherneurosi Physician/Medical Due to (or es e consequence of) 80 apoter milletin 980 for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the th signed by L□ Yee 2 No 3 Probably 4 Unknown strem Division of Vital Records, þ 8 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed peen completion of cause of deeth? has 1 Yes 1 Yes 2 No certificate funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P L 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Attending 1- ENaturel 5 Pending efter deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide 6 24 hours 29a. Certifier edicai 12 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and mannar es stated. completely (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and menner stated. To the Vilhin 2 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) Illen ho D0017565 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) APRIL 7, 1999 ,va L2 /21e A. J. Bollino 911 National

32. Registrer's Signetura

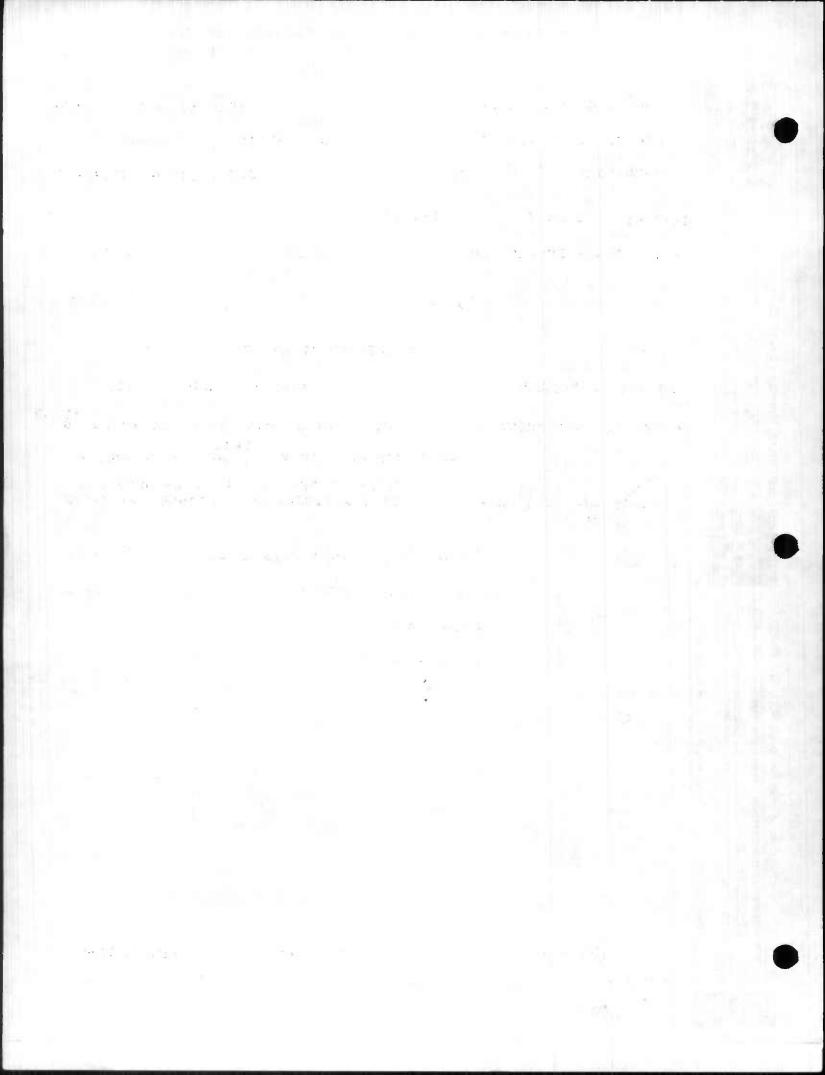
DHMH 16 Rev 6/95

State

Registrar

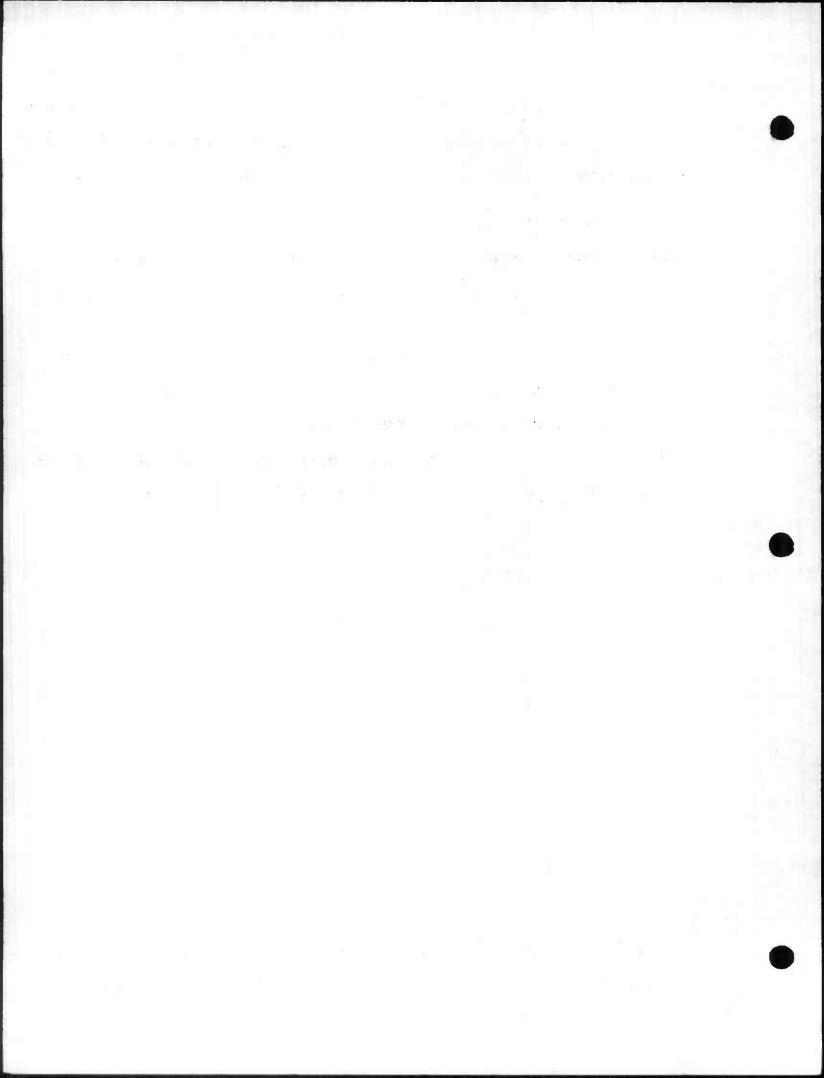
31. Date filed (Month, Dey, Year)

APR 09



| | | | Certificate of Death State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. |
|---------------------|--|---------------------|--|
| | Physici /Medi | | 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth Month APR 11 99 11:08 AF |
| | Examir Funeral Director | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Country of Deeth 4c. Coun |
| Т | arylend show dat | ٠ | Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita |
| | with the Mi | i Directo | MARYLAND PRINCE GEORGE ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18110 LIVINGSTON ROAD 20607 U.S.A. |
| 020 | J within 72 hours after death with the Marylend jiene. r than "natural", or Hems 23a or 28s-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Status 12. Waa Decedant Evar in U,S. Armed Forces? 1 Navar Married 2 Narried 3 Widowed 4 Divorced 12. Waa Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or Nolf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 14. Yas 2 No Specify: Specify: WHITE |
| Maryland 21215-0020 | d within piene. r then | Completed | 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 17. College (1-4or 5+) 18. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 18. Decedent's Education (Giva kind of work done during most of working life. DO NOT use retired) 18. Contract NEGOTIATOR 18. Contract NEG |
| yland | d 2 should be filed th end Mental Hygi 7 Is marked other traumatic event, tr | To Be C | 17. Fether's Neme (First, Middle, Last) ANDREW P. KENLON 18. Mother's Neme (First, Middle, Meiden Sumema) MYRTLE O. MILLER |
| | of Heelth end Item 27 is maintained | | 19e. Informent's Name/Relationship (Type, Print) BETTY L. KENLON-SPOUSE SAME AS #10 |
| Baltimore, | Peges nant of ant: If it | | 20a. Method of Disposition (Name of Cematary, crematory or other piece) 20b. Place of Disposition (Name of Cematary, crematory or other piece) 20c. Location - City or Town, Stata |
| Ba | Departi Departi Importu eny Inje | | 21. Signeture of Funarai Sarvice Licensea 22. Nama and Addrass of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardled or respiretory erreat, Approximate |
| | Physician /Medical Examiner | | 23a. Pert 1. Enter the diseases, or complications the caused the death. Do not enter the mode of dying, such as cardled or respiratory erreat, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Ceuse (Final disease or condition resulting in death) Due to (or es e consequence of): 23 Million Due to (or es e consequence of): |
| Box 68760, | eeth certificate be axecuted attending physician end I for use as the burial-transit | In/Medical Examiner | Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): |
| P.O. | res that the deett signed by the atte I be detached for | Physician/M | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| of Vital Records, | ew requi | Completed by | Typ: 7 Dia Bry Me U, 705 1 Yes 2 Tho 3 Probably 4 Unknown 24a. We an autopsy performed? 24b. Were autopsy finding a aveilable prior to completion of cause of death? |
| Vital F | iclan: The certificate rector, pag | Be | 25. Wes case reterred to medical exeminar? 1 Yes 2 No No Yes No No No Yes No No No No No No No N |
| Division of | Attending Physic deeth. ctor: After this by the funeral di | cation: To | 27. Menner of Deeth 1 Directoral 5 Pending 2 Accident Investigation 2 28b. Date of injury (Month, Day Year) 28b. Time of Injury Work? M 1 Year 2 No |
| Divis | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | I Certification: | 3 Suicide 4 Homicide 28e. Pleca of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |
| | To the Hos within 24 hc To the Fun completely | Medical | 29a. Certifier (Check only one) 1 ☐ Certifying Phyalcian: To the best of my knowledga, deeth occurred at the time, dete and piece, and due to the cause(s) end manner as stated. 2 ☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and mannar stated. 29b. Signature end title of cartifier 29c. Licanse number 29d. Date signed (Month, Day, Year) |
| | . , , , , | | 30. Name and eddress of person who complated cause of death (item 23a) (Type, Print) |
| | Sta Registr | | 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) R. M. NEDZBALA, MD 1/70/Liui Noston M. P. Washireton, Md. 20194 31. Date tiled (Month, Dey, Year) APR 1 9 1999 APR 1 9 1999 |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First, Middle Last) **Physician** April 1, 1999 6:00PM Mary A Keller /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hyattsville Prince Georges 5009 70th. Place If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1□M 2 F Yrs. 79 Director 577-24-2174 Pennsylvania Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer death with the Meryland Department of Heelth end Menlel Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28a-1 show any injury or other traumatic event, it a Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d, inside City Limits XX Yes 2 No Directo Maryland Princ Georges Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 5009 70th, Place 20784 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Bleck, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Gov't Printing Office 12 0 Printer Assistant 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leland F. Myers Bertha Μ. Coss P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 70th. Place Hyattsville, MD 20784 (Husband) Frank Keller 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/5/99 Suitland, MD Cedar Hill Cemetery 22. Name and Address of Facility
Rendon/Hale Funeral Home 21. Signature of Juneral Service Licansee 9013 Annapolis Rd. Lanham, MD 20706

23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Respiratory Insufficiency **Examiner** Due to (or as a consequence of): Examiner 3 Mos. Metatstic Small Cell Carcinoma physician end the buriel-trensit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) resulting in death) Last SB attending p esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown Brain Metastates þ The law requires 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed Hepatic Metastates certificate hes b 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital I To the Hospital or Attending Physician: within 24 hours efter deeth. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖫 Residenca 6 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No n 24 hours efter deeth.

Funeral Director: Aipletely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide XCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier 29c, License number ratur O. Welt D23743 April 5, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. Greenbelt Md 20770 Martin Weltz 31. Date filed (Month, Day, Year) APR 0 7 1999 32 Registrar's Signeture

State Registrar

The same of the sa

| ician | | Decedent's Nan | | m m | | | | | | | | | 2. Data Mont | h | h Day | Yaar | 3. Time |
|--|--|---|--|-------------------|--|---|---|--|--|--|--|--|--|--|--|--|--|
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| | 10e | . Street and Nu | | este | s I | | Der | TIM | 10f. Zip | Coda | | | | 10 | Og. Citizen of | What Co | ountry? |
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Birthplace (Stete or Foreign Country)

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SEPT. 17 1911

6. Sex 1 □ M 2√2 F

7. Age (In yrs. lest birthday)

Yrs.

10c. City, Town or Location

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Physician

/Medical

Examiner

Funeral

Director

5. Social Security Number

579-24-0093

10a. State

Usuel Residence of Decadent

10b. County

| | with the Marylen a or 28a-f show | tor | 10a. State 10b. County MARYLAND NONE | N.T. | City, Town or Local BALTIMO | | | | | 10d | I. fnside City Limits No Yes 2□ No |
|-------------|--|--|---|---|-------------------------------------|--|--|---------------------------------|--|------------------------------|--|
| | the 28s | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | I0g. Citizen of Wi | hat Country | 17 |
| | h with | | 816 HARLEM AVEN | IUE | | 2120 |)1 | | US | , | |
| 5-0020 | 72 hours efter death with the Marylen natural', or liems 23a or 28a-f show picel Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Merried 30 Widowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | /as Decedent of H Yes, specify Cube | lispanic Orlgin? (Spec en, Mexican, Puerto Ri Specify: | fy Yes or No- can, etc.) | 14. Raca Bleck Specify: | - American , White, etc | |
| Š | n 72 hours "natural", | | 15. Decedent's Edu | cation | 16a. Deced | ent's Usual Occup | etion | T | 16b. Kind of Bus | | |
| 212 | within 7: ene. than "n | piet | (Specify only highest grede Elementery/Secondary (0-12) | completed) College (1-4or 5+) | (Give I | ind of work done O NOT use retired | during most of working | | | | |
| 7 | Hygin Hygin other | Be Completed | 12th 17. Father's Neme (First, Middle, Last) | 2 yrs. | OFFSE | T PRESS | 18. Mother's Name (| | FEDERAI Maiden Sumeme | | VERNMENT |
| Maryland | should by and Mente marked | 2 | JAMES MURRA | Y | | | UNOBTA | INABL | E | | |
| a a | and and is ma | | 19e. Informant's Name/Relationship (Ty | pe, Print) | 19b. Mailin | Address (Street | end Number or Rurel | Route Number | r, City or Town, S | itete, Zip C | ode) |
| attimore, N | Peges 1 end ment of Health ant: If item 27 ury or other tr | | ETHERL HODGES (S 20e. Method of Disposition 1 Runial 2 Cremation 3 R 4 Donation 5 Other (Specify) | 20b. emovel from State | Placa of Dispos cemetery, crem | | ce) | Date | ORE, MI 20c. Location - C AUREL, | ity or Town | |
| Balt | permit. Pege Department of Important: If any Injury or once. | | 21. Signeture of Funerel Service Licanso | | W | | SE & SONS | | | | 2.1 |
| | Physician | 100 | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or | cations thet caused the dec ne ceuse on each line. | | | | | | In | pproximete nterval Between Onset and Death |
| 1 | /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in death) | Atheroscli Alzher | notre (| Tardio i | is cul or | Disea | ise | | Leavs |
| | | -e | | 17-1 Due to | (or as e consequ | ience of): | | | | | |
| | uted d ansit | Examiner | | | (or as a consequ | | - | | | | |
| Ď, | be executed sician end buriel-transit | | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury | Due to | (or as a consequ | enca or _i . | | | | | |
| 09/8q | hysici the bu | licai | Ceuse (Disease or injury thet Initiated events resulting In death) Last | Due to | or es a consequ | enca of): | | | | | |
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| ă | death e etter ed for u | iciai | Part fl. Other significent conditions con | tributing to death but not re | sulting in the un | dedving cause giv | en in Pert I | 23h. Did to | obacco usa cont | ribute to th | he cause of gleath? |
| J. | by th | hys | | | outing in the till | outlying oddoo giv | on with out i. | | es 2 No | | |
| Ś | gned bed | by | | | | | | | | | |
| Cord | v requires been sign should be | Completed | | | | | | 24e. Wes e | | availe | e eutopsy findings able prior to |
| ec C | 2 S S | npie | | | | | | | | of dea | oletion of cause ath? |
| Ial | Pa as | S | | | | | | 1 🗆 Y | es 2 No | 1 🗆 Y | Yes 25 No |
| X | certifica ector, | Be | 25. Was case referred to medical examiner? | ospitel: | | Oth | 26. Plece of Death (| Check only or | ne) | | |
| 5 | Physicie this cert ral direct | : To | 1 163 2 10 | 1 Inpatient 2L | ER/Outpatient | | 4 🗆 Idaising Home | | | | |
| 5 | tending P deeth. tor: After the funer | 27. Manner of Deeth 1 1 Naturel 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury at Work? 1 1 Yes 2 No | | | | | | | | | |
| DIVISION | al or Atte s efter de il Directo ed in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Placa of Injury - At I building, etc. (Spec | nome, farm, stre | et, factory, office | 28 | f. Location (Si City or Town | treet and Number n, Stete) | r or Rural A | loute Number, |
| | To the Hospital or Attending Physicie within 24 hours efter deeth. To the Funerel Director: After this cert completely filled in by the funeral direct direct. | edicai (| 29a. Certifier (Check only one) 1世 Certifying Phys 2 Medical Examin | fclan: To the best of my kn er: On the basis of examin end manner stated. | owledge, deeth ation and/or inve | occurred et the tinestigetion, in my o | ne, dete end place, en pinion, death occurred | d due to the co | euse(s) end men ate end place, an | ner as state nd due to th | ed. e ceuse(s) |
| | within To the Comp | X | 29b. Signature end title of certifier |) 1 | | 29c. Licens | | 2 | 9d. Dete signed | (Month, Da | y, Year) |
| | | | Neone C/ | Wills To | InD. | 09 | 1365 | 1 | Tarch 2 | 7,19 | 99 |
| | | | 30. Name end address of person who con George E. W. | mpleted cause of death (Ite | om 23a) (Type, P | | Novah B | | | | 2123] |
| | Sta | 10 | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | neture | | | | | | |

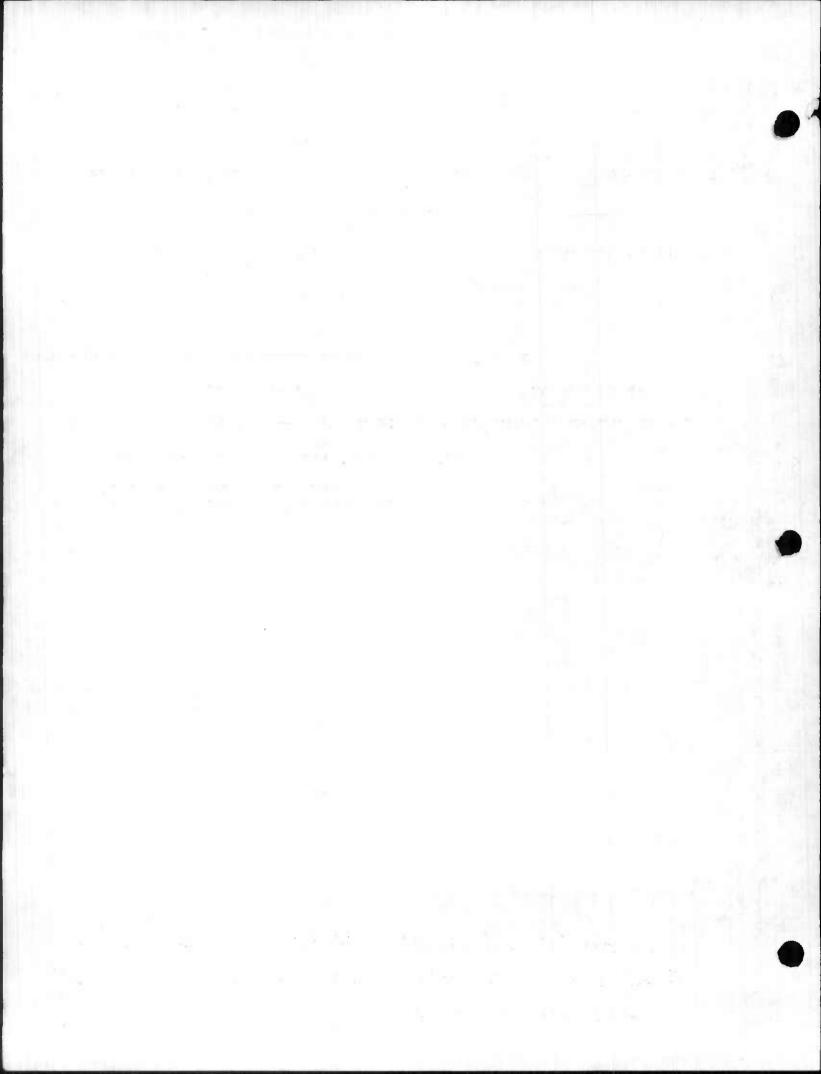
32. Registrar's Signeture

B. Spark

APR 0 5 1999

State

Registrar

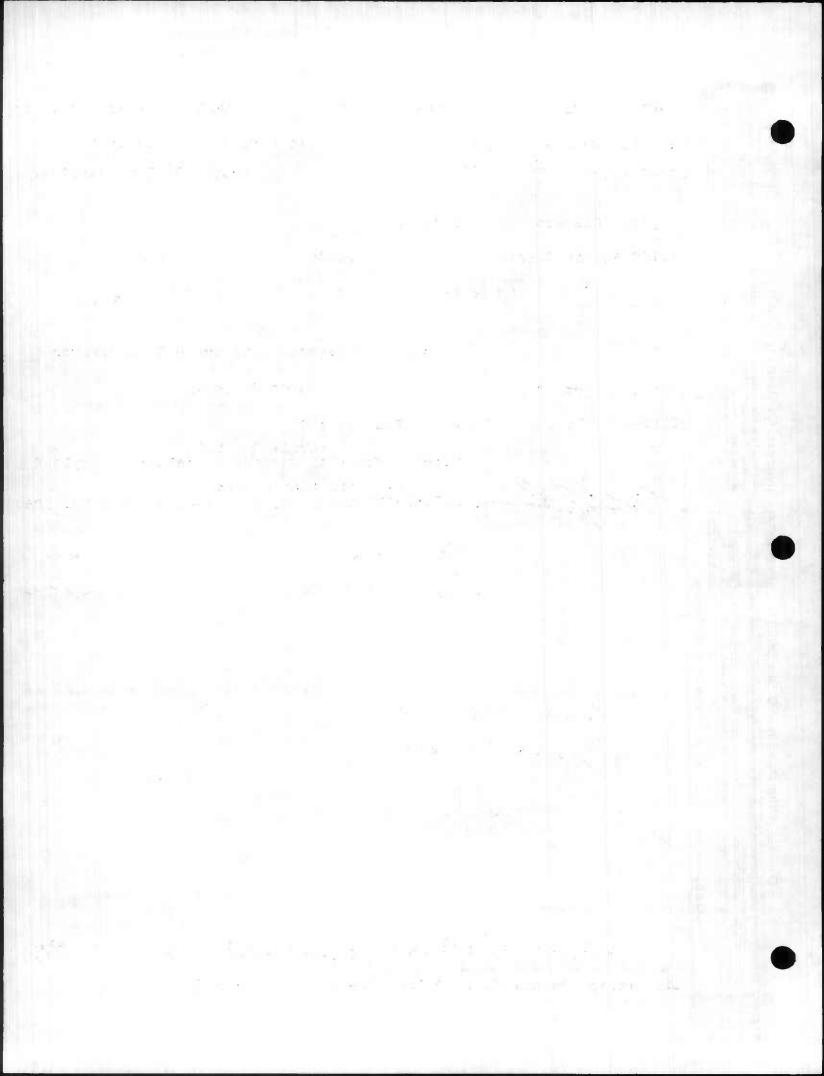


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Month Year **Physician** ROY 31, 1999 ARTHUR LEWIS JR MARCH 14:00 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
Sept. 13, 1919 Calvert 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 79 234-22-6194 Director Maryland Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10c. City, Town or Location 10d. Inside City Limits Hygiene. Hygiene. Wher then 'neturel', or frems 23a or 28a-f show ant, the Medical Exeminer must be notified at 10e State 10h County 1 Yes 2 No Maryland Calvert Directo Solomons 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 11100 Asbury Circle 20688 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Dives 2 D No. If Yes, Give WW I I Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 2q 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supply Management Officer U.S. Government 7 is marked other it 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file ment of Heelth and Mental Hant; If Itam 27 is marked oth lury or other traumatic avan Be Maude M. Lewis Roy A. Lewis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Eileen K. Lewis Wife Same as #10 20b. Place of Disposition (Name of cametery, crematory or other place pril 3, 1999 20a. Method of Disposition 20c, Location - City or Town, State 1 ABurial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service Licenses M006684270 HAwthorne Rd., Indian Head, Md. 20640 e, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PNEUMONIA /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner CANCEL physician end s the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobecco usa contributa to the cause of death? signed by the 1 Syes 2 No 3 Probably 4 Unknown Fibrilation P 24b. Were autopsy lindings available prior to completion of ceuse of death? Completed Hy per tension 24a. Was an autopsy peen page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funerst Director: After this certifica director, Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, 1erm, street, fectory, office building, etc. (Specify) in by 4 Homicide • Funerat to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fil edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Joseph Barth, M.D. Prince Frederick, MD 20678 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State APR 12 March Registrar

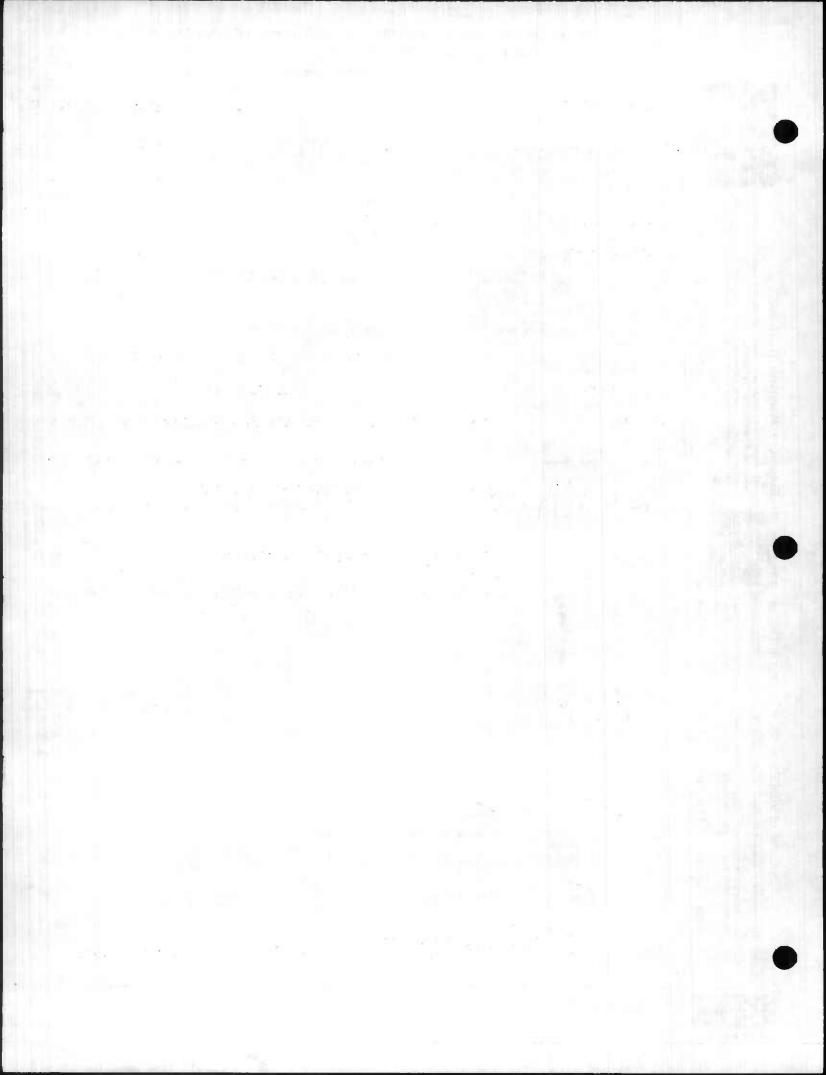
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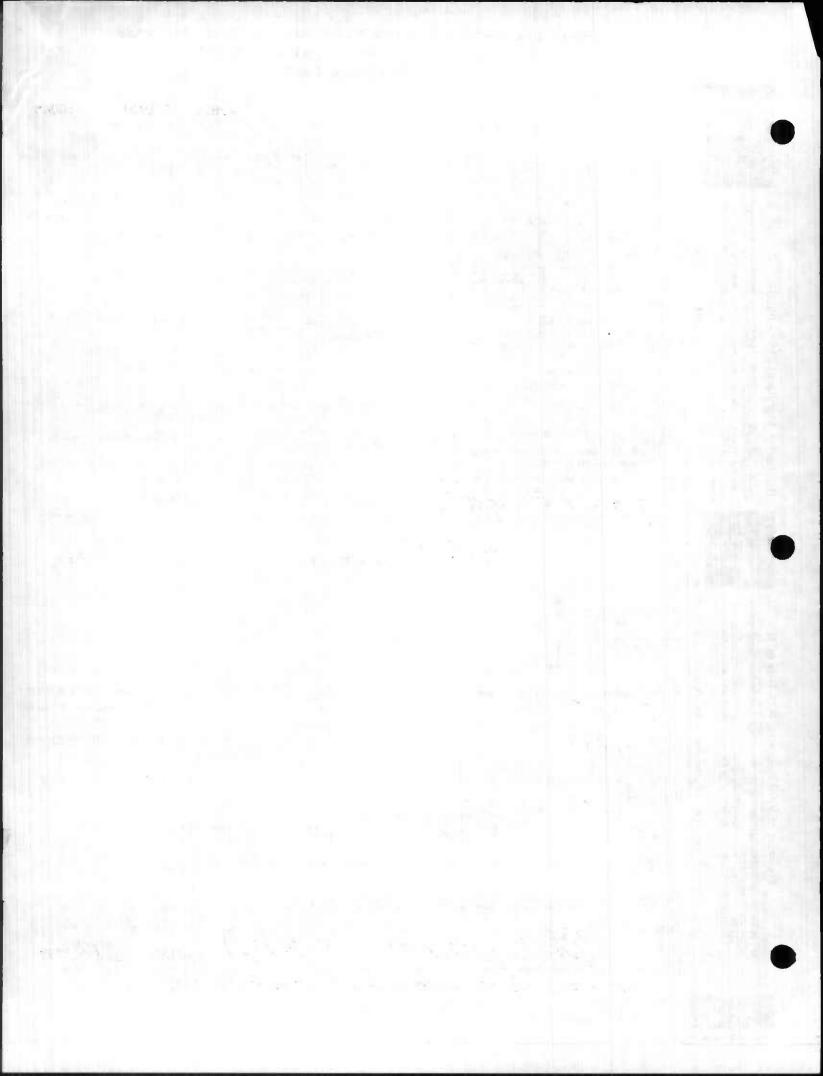
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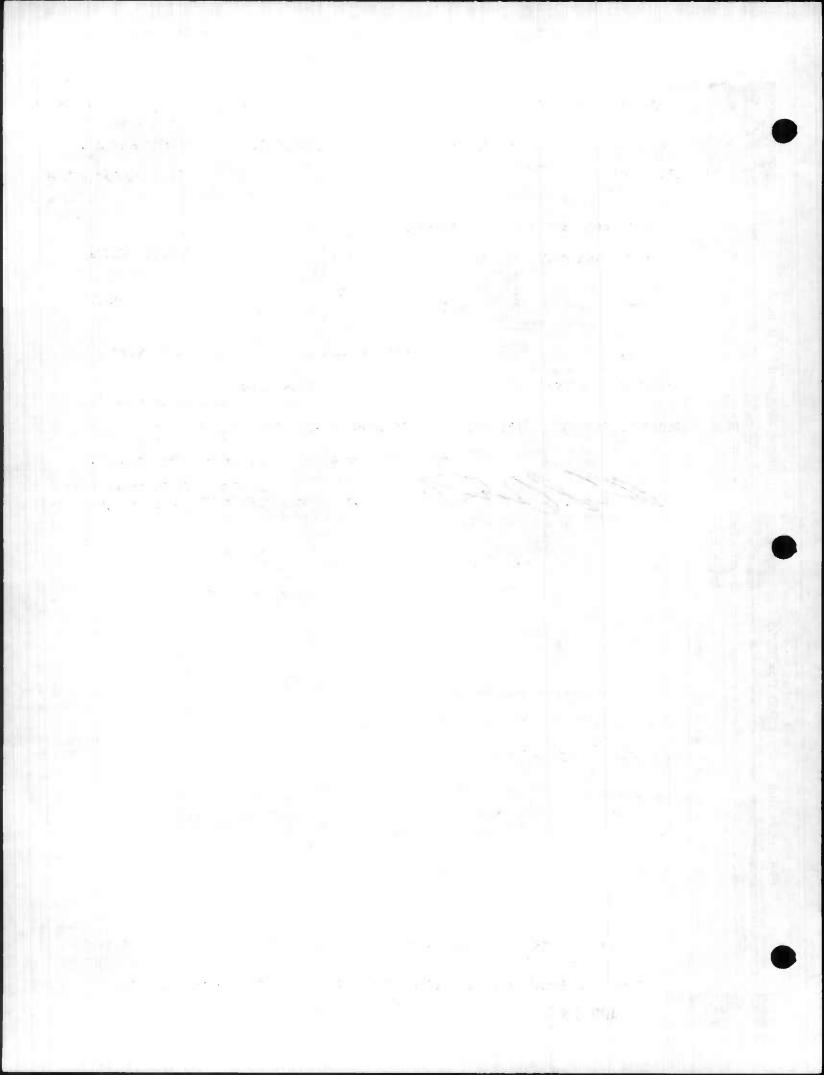
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| Examiner | Sacred Heart Ho | spital | | | Cumber | land | | Allegany | |
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| firer death with the Mar frame 23s or 28s-fol inner must be notified Funeral Director | 10e. Street and Number 947 Seton Drive | e, Apt. 3 | | 10f. Zip Code | 2150 | 2 | 10g. Citizen of What Country? | | |
| 5-0020 72 hours after death with the Maryland natural', or items 23s or 28s-1 show diest Examiner must be notified at sted by Funeral Director | Widowed 4 □ Divorced | I2. Was Decedent Ever in U Armed Forcest 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | Vas Decedent of I Yes, specify Cub | Hispanic Origin? ean, Mexican, Pu Specify: | (Specify Yes or Nerto Rican, etc.) | Blac | e - American Indian, k, White, efc. : white | |
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| Baltim permit. Peg Department important: I any Infury o | 21. Signature of Funaral Sarvice License | | 22 | scarper | 1st Frun | | me P.A. | | |
| Physician /Medical · Examiner | 23a. Paryl. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | Acute | or as a consequent | unori | ng, such as card | liac or raspiratory | arrasi, | Approximate Interval Batwean Onset and Death | |
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| cords, requires the been signed should be deted by | | | | | | | s an autopsy formed? | 24b. Were autopsy findings available prior to completion of cause of daath? | |
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| To the Hospital of within 24 hours er To the Funeral Drompletely filled I wedloal Ce | 29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination | clcian: To the bast of my kniner: On the basis of examinated manner stated. | owledga, daath ation and/or Inv | occurred at the trastigation, in my | ime, date and pla opinion, daath o | ace, and dua to the occurred at the time | e cause(s) and ma a, data and place, | annar as statad. and due to the causa(s) | |
| To the Committee of the | 29b. Signature and title of certifier | Junos | mo | 29c. Licen | se number | 181 | | d (Month, Day, Year) | |
| , | 30. Name and address of person who co | mplated cause of death (Ite | m 23a) (Type, I | Print) | | () | APRIL | 100,1999 | |
| held | GARY WAGONER 31. Date filed (Month, Day, Year) | M.D. 925 BIS | - | SH ROAD | CUMBERL | AND MD | 21502 | | |
| State Registrar | APR 1 2 1939 | 10 may | de justin | | | | | | |

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| | Physiciar /Medica | 1 | THOMAS J, MORTIN | | | | | | | APRIL | 6, Day | 1999 | 8:40 | PM |
| | Examine | r ' | la Facility Name (If not institution, give | street and numbe | r) | | | 1 | 4b. City, Town, | or Location of Dea | th 4c. | County of Dee | th | |
| | Funeral Director | | ANNE ARUNDEL ME] 5. Social Security Number 6. So 214 05 0953 12 Usual Residence of Decedent | | | lest birthday, 87 Yrs. | Months | | | | rth a <i>y, Year)</i> | | NDEL thplace (State buntry) DE ISL | |
| | Mond | - | 10a. State 10b. County | | 10c. Cit | ty, Town or L | ocation | | | | | | 10d. Inside | City Limits |
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| 020 | w 0 <u>9</u> , | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Deceder Armed Forces 1 Yes 2 If Yas, Give Year or Dates | 3?] No | | If Yes, speci | | Specify: | ? (Specify Yes or N uerto Rican, etc.) | 0- | Black, White | | |
| 21215-0020 | C | Completed | 15. Decedent's Ed (Specify only highest grad Elemantary/Secondary (0-12) | ucation | | 16a. Dece | dant's Usual kind of work DO NOT use | k done | duning most of | working | 16b. K | ind of Business | /Industry | |
| | be filed within tel Hygiene. d other than event, tre M | 0 | 12 | 2 | | BUSI | NESS M | ANA | | | - | . NAVY | | |
| Maryland | d out | 0 26 | 17. Father's Neme (First, Middle, Last) THOMAS C. MORTIME | | | | | | ELLA | Name (First, Middle DIGGS | | | | |
| Mar | ie m | | 19a. Informant's Name/Relationship (7 | | , | | | | | r Rural Route Num | | | Zip Code) | |
| | s 1 end F Heelt tem 27 other 1 | - | JAMES W. JACKSON 20e. Mathod of Disposition | (FRIEND | 20b. F | Place of Disp | WINDS osition (Nam | e of | | NAPOLIS, | | cation - City or | Town, State | |
| OIII | 90 = 0 | | 1 Burlal 2 Cremation 3 4 Donation 5 Other (Specify | | 0 | cemetery, cre | | | | 04-10-99 | GLEN | BURNTI | E MD. | |
| Baltimore | permit. Pe Departmen Important: any Injury pnce. | | 21. Signature of Emeral Service Licgo | 1/26 | 7 | 7) | 2. Neme and | | ss of Facility | JOHN M. | rayl(| R FUNE | RAL HO | ME, INC |
| 68760, | ysicla | ical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. 0000 b. 0000 | Due to (d | or as a conse | quence of): | EN | t bl | see leve | | | | |
| Box | etten d for u | Ctar | Part II. Other significant conditions of | entributing to death | but not ree | culting in the | undariving ca | auca on | (an in Part I | 23h Die | tobacco | use contribut | a to the caus | n of death? |
| , P.O. | v requires that the death been signed by the ette should be detached for | y Pmys | Sugarent | wells | de | hja | da | Jusa gr | an in Faiti. | | Yes 2 | | Probably 4 | |
| Vital Records, | aw requires is been sig 2 should b | Completed by PhysiciaryMed | collectito of | Legs | | | | | | 24a. Wa | s an auto formed? | psy 24b. | Were autops available pric completion of of death? | or to |
| E E | sician: The law certificate hes birector, pege 2 si | E 0 | | V | | | | | | 10 | Yas 2 | [¥No | 1 ☐ Yes 2 | 2□ No |
| Vita | ysiclan: is certific director, | Q C | 25. Was casa referred to madical exeminer? | Hoseitali | | | | | | Death (Check only | one) | | | |
| of | this alo | non: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investigation | 28a. Date of Ir (Month, I | Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing | | | | | 28d. Dascribe | sidence 8 Other (Specify) e how injury occurred | | | |
| - | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral professional and the funeral and the funera | 27. Manner of Death 2 Accident 2 Accident 3 Suicida 4 Homloide 2 Accident 6 Could not be determined 2 Be. Place of Injury 2 2 2 2 2 2 2 2 2 | | | | | | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | | | um <i>ber,</i> |
| | To the Hospital o within 24 hours of To the Funeral Di completely filled i | edicar | 29a. Certifier Check only one) Certifying Ph | a and placa, and due to tha causa(s) and manner as a death occurred at tha tima, data and place, and due t | | | s stated. e to the caus | e(s) | | | | | | |
| | within To th | | 29b. Signeture end title of certifier | 0 | 11 | 0 | 29c | . Lican: | se number | | | ite signed (Mon | | 7) |
| | | | 67109086 | mot | XA | 1000 | 00 | 1/9 | 756 | 7 | API | RIL 07, | 1999 | |
| | | | 30. Name and address of person who of GREGORY A. MIT | | | m 23a) (Type 21 RID | | VE. | #401 | ANNAPOLI | S,MD | 21401 | | |
| | State Registra | - | 31. Date filed (Month, Day, Year) APR 0 8 19 | 99 32. Regin | strar's Sign | ature 6 | de | rou | 2 | | | | | |

Registrar DHMH 16 Rev 6/95



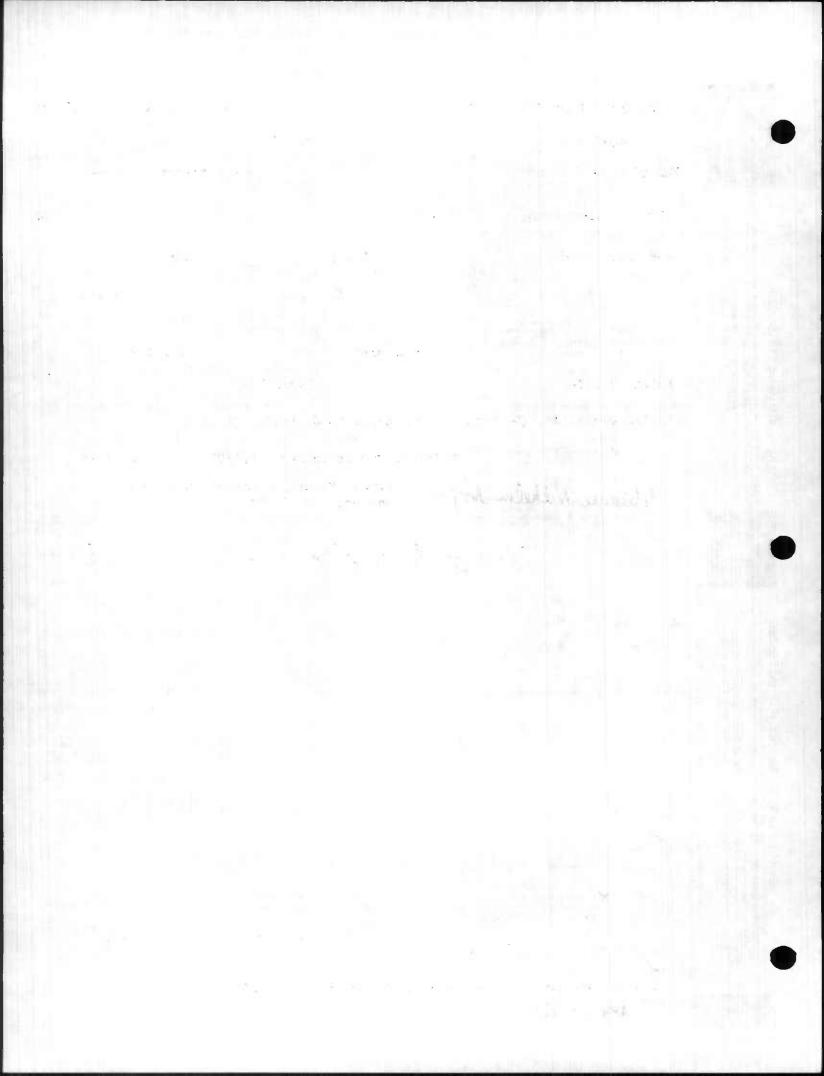
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month 04 Physician 1999 02 ROSE JUDITH DVORNIK MORSE 1:30 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 686 Capri Road Arnold Anne Arundel 5. Sociel Security Number 7. Age (In yrs. lest birthday).
73 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 12/24/1925 Birthplace (State or Foreign
Country) **Funeral** Months Deys Hours 1 M 2 XF Yrs. 220 60 0438 Yugoslavia Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow treumstic event, the Medical Examinal must be notified at MD Anne Arundel Arno1d 1 Yes 2000 Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 686 Capri Road 21012 USA permit. Peges 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23s any injury or other treumatic event. the sec Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Merried 2K Married Specify: White Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Mateo Dvornik Klara Levi 0 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Charles Morse, Jr. (husband) 686 Capri Road, Arnold MD 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Metropolitan Crematory 4/5/99 Alexandria VA 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility
Advent Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Annapolis MD 21401 Approximate Intervel Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in deeth) money XX **Examiner** Due to (or as e consequence of): Examiner ician end buriel-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initieled events resulting In death) Last Due to (or as e consequence of): that the death certificate be exec Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of): 98 ettending use ŏ signed by the e 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 00 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings evailable prior to 24e. Was en eutopsy performed? Completed peen completion of cause of death? has pege 2 20 No 1 Yes 1 Yes 2 No certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and manner es stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. edical 29e. Certifier 29b. Signature and 19th 60c 29c. License number 29d. Date signed, (Month, Dey, Year) 30. Name and eddress of perso who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Rd Stanley Watkins, MD Annapolis MD 21401 31. Dete filed (Month, Day, Year) APR 0 6 1999 degistrar's Signature State

DHMH 16 Rev 6/95

Registrar



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| | State of Maryland | / Department of | Health and Me | ental Hygiene |

| an | 1. Decedant's Nama | (First, Middle, La | ist) | | | tificate (| | 1 | 2. Dete of De | Reg. No. | - | 3. Tima | of Death | | |
|--|--|--|---|--|--|----------------------------|--------------------------|--|------------------------------|------------------|--------------------------|--|-------------------|--|--|
| 311 | MARY E. | MARION | | | | | | | Month | Day | Year | 1 | :30PM | | |
| al | 4a Facility Nama (If | not institution air | re street and number | ar) | | - | 4 | b. City, Town, or Loc | APRIL cation of Deat | | 999 ty of Death | | , , JOI II | | |
| er | 16424 AB | | | ., | | | | ITCHELLVI | | | | ORGE' | c | | |
| | 5. Social Sacurity Nu | | | Age (In yrs. la | nst birthday) | If Undar 1 Y | aar | If Undar 24 Hrs. | 8. Data of Bir (Month, Da | | - | nplece (State | | | |
| | 579-30-42 Usual Rasidence of I | .84 | I□M 2⊠F | 72 | Yrs. | Months Da | ays | Hours Min. | (Month, Da | o, 1926 | | JERS | | | |
| - | | 10b. County | | 10c, City, | Town or Loc | ation | | | | | | 10d. Insida | City Limits | | |
| to | MARYLAND | PRINCE | GEORGE'S | M | TTCHEL | LVILLE | | | | | | 1 □ Y€ | s X No | | |
| Funeral Director | 10e. Street and Num | ber | | | | 10f. Zip Coo | da | | | 10g. Citizan of | What Cou | untry? | | | |
| | 16424 ABB | EY DRIVE | 7 | | | 2071 | 5 | | | UNITE |) CTA | TEC | | | |
| Der | 11. Marital Status | | 12. Was Daceda | nt Ever In U,S | S. 13. V | | | spanic Origin? (Spen, Maxicen, Puerto F | cify Yas or No | | ce - Amar | rican Indian, | | | |
| by Fui | 1 Navar Marrie | | Armed Force 1 Yas 2 If Yes, Giva Yaar or Data | Xνφχ | | Yas, specify (☐ Yas 2Ĭ | | Specify: | tican, atc.) | Speci | ack, Whita by: WH | ITE | | | |
| 8 | | 15. Decedant's E | ducation | | 16a, Deced | ent's Usual Oc | CCUDS | ation | | 16b. Kind of E | | | | | |
| Completed | (Specification (Speci | fy only highest gri | ade completed) | Dr. 5.1) | (Give I life. D | aind of work do | one d | during most of working) | 9 | | | | | | |
| mo. | 12 | oary (0-12) | Collega (1-4d | J 3+) | HOME | MAKER | | | | OWNED | HOME | | | | |
| BeC | 17. Fathar's Nama (F | First, Middle, Last |) | | | | | 18. Mothar's Nama | (First, Middle | | - | | | | |
| OB | (UNKNOWN) |) | | | | | | (UNKNOWN |) | | | | | | |
| | 19a. informant's Nar | me/Ralationship (| Type, Print) | | 19b. Mailin | g Addrass (St | reet a | and Number or Rura | - | er, City or Town | n, State, Z | (ip Code) | | | |
| | M. DARLEN | E RIDEN. | DAUGHTE | R | 1717 | BASIL 1 | WAY | Y, GAMBRII | LLS. MA | ARYLAND | 210 | 154 | | | |
| | 20a. Mathod of Dispo | osition | | 20b. Pla | | sition (Name o | | | Date | 20c. Location | | - | | | |
| | | Cremation 3 5 Othar (Special | Ramoval from Sta | rar . | | OLN CE | | | /6/99 | DDENTTO | 000 | MADVI | ANTO | | |
| | 21. Signature of Fun | | | FUK. | | Nama and A | | e of Facility | | BRENTW | | | | | |
| | W. | 16 | LULION | | | | | FT. | | LN FUNE | | | | | |
| - | 23a Part I Enter the | a disease hiloom | inlications that caus | ad the death | | | | ENSBURG RO | | RENTWOO | DD, MD | | | | |
| | 23a Part1. Entar the shock, or heert | feilure. List only | ona cause on each | line. | | | | - ^ | rospiratory a | , | | Approxim Interval B Onset an | etween d Deeth | | |
| | Immediata Causa (F | Final | | | B | veas | + | CA | | | | 1 111 | \ | | |
| | disaase or condition resulting in death) | | 8 | | | | | | | | | 1 40 | • | | |
| - | | | | Dua to (or | as a consaq | uance of): | | | | | į | | | | |
| Examiner | 0 | | b | Due 4- /r- | 00 0 000000 | innoc of): | | | | | - | | | | |
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| ca | Sequantially list con- if any, leading to im- cause. Enter Under Cause (Disease or in that initiated avents | njury | C | Due to /or | 96 9 000600 | iance of/: | | | | | - | | | | |
| 8 | rasulting in deeth) La | ast | | DUM TO (OF | as a consaqu | anto Otj: | | | | |] | | | | |
| 3 | | | d | | | | | | | | | | | | |
| icia | Part II. Other signific | ant conditions | ontributing to death | but not recol | ting in the | darlylog cauc | a nive | an in Part I | 23h Did | tobacco use c | ontribute | to the caus | e of death? | | |
| hys | aren. Outer signific | sern contitions (| willing to death | OUL HOL FASUI | ang ar ma ur | Garry Hig Causi | a give | an miralli. | | Yes 22 No | | obably 4 | | | |
| y P | | | | | | | | | 10 | 940 | V I I'I | Country 4 | _ onknown | | |
| D D | | | | | | | | | 24a. Wes | an autopsy | 24b. \ | Were autops | y findings | | |
| lete | | | | | | | | | perfe | ormed? | | available price completion of death? | f ceuse | | |
| E | | | | | | | | | | Van aka | | | □ No. | | |
| | OF Mes and | nel de me a dire d | | | | | | | | Yas 2 No | | 1 ☐ Yas 2 | U NO | | |
| U 25. Was casa relerred to medical axaminar? | | | | | | | Otha | 26. Place of Death | 1 / | | | ** 1 | | | |
| 00 | | NO | Hospital: 1 Inpa | | P/Outpatien | | Injury | 4 LI Nursing Hor | - | how injury occu | | cify) | | | |
| 2 | 1 ☐ Yas 2 N | 27. Mennar of Death 12 Neturel 5 Pending (Month, Day Year) 28b. Tima of Injury | | | | | | | .cu. Dastille | anjury occi | | | | | |
| 2 | 27. Mennar of Death | 5 Pending | 2 Accident invastigation 3 Suicida 6 Could not be | | | | | | | (Street and Nur | nber or Bu | ral Route M | ımber | | |
| 2 | 27. Mennar of Death 12 Neturel 2 Accident | invastigatio | e on Dian of | loiune . At h | 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) | | | | | | | office 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 2 | 27. Mennar of Death 12 Neturel 2 Accident 3 Suicida | invastigatio | e 28a. Placa of | Injury - At hor atc. (Specify) | na, farm, stre | | | | City or To | wn, State) | | | | | |
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| edical Certification: To | 27. Mennar of Death 1 Neturel 2 Accident 3 Suicida 4 Homicide 29a. Certifier (Check only | invastigatio 6 Could not b detarminad | 28a. Placa of building, | atc. (Specify) st of my know | rladge, deeth | estigetion, in r | he tim | | ind dua to tha | causa(s) and n | e, end due | to the cause | | | |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14 4 MARCH JOSEPH LEE MCFARLAND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not Institution, give street end number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Days Hours Min Yrs Director 53 05-30-45 Norfolk, VA 227-58-1472
Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Yes 2□No Directo Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "naturel", or items 23s or the Modical Examiner must be 8103 Oakwood Drive 20735 USA Pages 1 end 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "naturel", or Items 23. Funeral 11. Meritel Status Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1966-69 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Security Guard Holy Cross Hospital 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Robert McFarland Josephine Vines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Billie Yvonne McFarland/Wife 8103 Oakwood Drive, Clinton, Maryland Item 2. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) permit. Pages Department of Important: If it eny injury or o Roosevelt Memorial Cem 4-9-99 Norfolk, VA 22. Name and Address of Facility Strickland Funeral Services, PA 21. Signature of F 6500 Allentown Rd., Camp Springs, MD 20748 to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final . ARTERIOSCUEROTIC, CARDIOVASCULAR DISBASE disease or condition resulting in death) Examiner Examiner physician end s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 88 for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the s been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy completion of cause of death? s certificate has I 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica director. Be 25. Was case referred to medical 26. Place of Death (Check only one) niner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 2 pelli 24 hours a Hospital Medical 29a. Certifier 🖳 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. ompletely i 2 Medical Examiner: On the basis of examiner and manner stated. plnetion and/or Investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 23a) (Type, Print) THAL DRIVE, CHEVERLY, MARYLAND 3001 82. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 6 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month PCH 30 **Physician** 4:50 pm 1499 Josie Belle McIlwain /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince Georges Hospital Cheverly Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 TF Months Yrs. 579-30-9827 83 Sept. 12, 1915 Rocky Mount, N.C. Director Usual Residence of Decedent with the Meryland 10d. Inside City Limita th and Mentel Hygiene.
7 is marked other than "natural", or items 23a or 28s-f show trammetic event, the Medical Examinet must be notified at 10a State 10b. County 10c. City. Town or Location 1 X Yas 2 □ No Director Prince Georges Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter deeth v. Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural", or frems 23a and injury or other traumatic event, the Medeal Examiner research. 3001 Queenschapel Rd. #303 20712 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 Yes, 2 W No If Yes, Give Yaar or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Navar Married 2CXMarried Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) 5th Housewife Private 18 Mother's Name (First Middle Maiden Surname) 17. Fathar's Name (First, Middla, Last) Clarence Land Jimmie Ann Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 3001 Queenschapel RD #303 Mt. Rainier, MD. 20712 Richard McIlwain/Husband 20b. Place of Disposition (Nama of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4-3-99 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cem Laurel, Md. 22. Nama and Addrass of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licansee 4217 9th St. NW Washington, DC 20011 23a pm. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, hock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physiclan** /Medical Immediate Cause (Final SENSIS disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner monThs 10 Pl 3 901 physician end the buriel-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or Injury that initiated evants resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequenca of): ettending p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RTERIOSCHEROTE à 24b. Were eutopsy findings available prior to been si Completed 24a. Wes en autopsy performed? completion of ceuse of death? After this certificate has funeral director, page 2 1 ☐ Yas 2 Z No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 EInpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number 01852 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Queenshory Rd H4attsville MD 20781 1 DE VORE MA 4203 31. Date filed (Month, Day, Year) APR 0 5 1999 22. Registrar's Signature State Registrar

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Physician /Medical **Examiner**

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

vascular o lisease 24b. Were autopsy findings available prior to completion of cause of death?

26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 1 Yes 2 No

25. Was case referred to medical 1 Yes 2√ No 27. Menner of Death

28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 Netural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier

4 ☐ Homicide

15/Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D19609

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

RAMAN R. TULLIMD 3503 PERRY STREET, MOUNT RAINIER, MD 20712

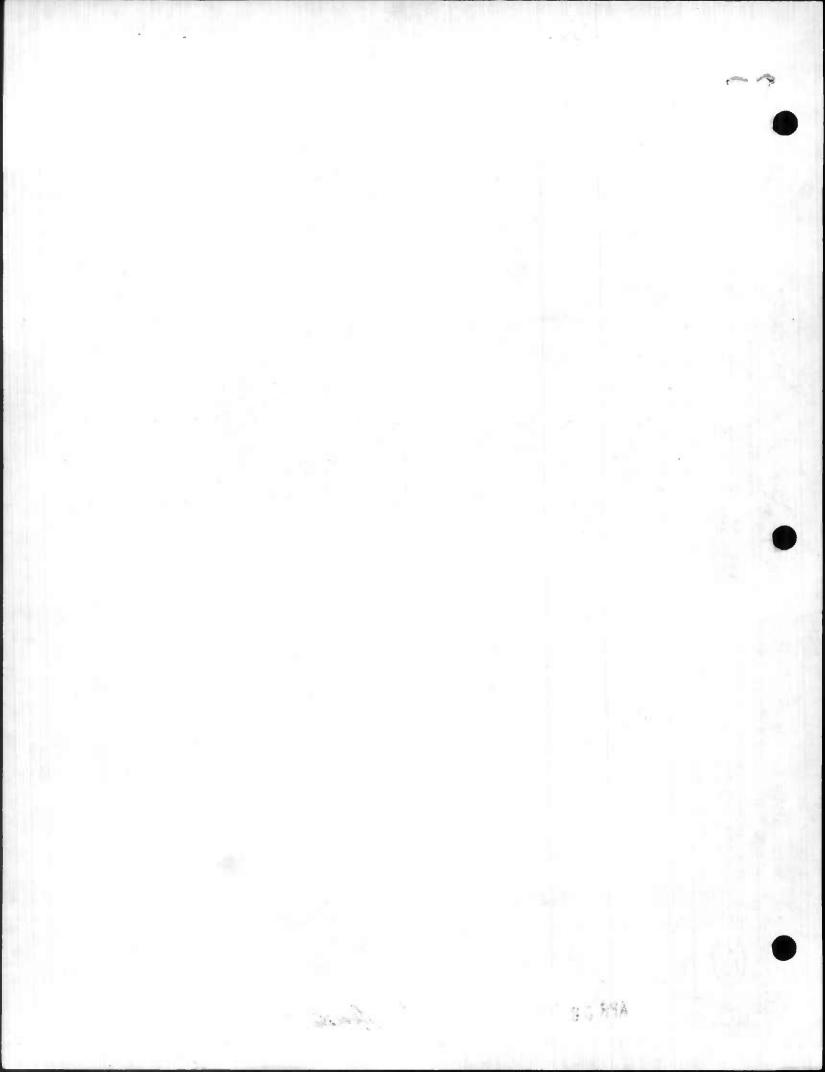
State Registrar

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31. Date filed (Month, Day, Year) APR 0 8 1999

32. Registrar's Signature





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| , | Holy Cr | | | | | 5 | . H Lindo | or 1 Year | | Lver | Spring | | gome | |
| | 5. Social Security N | | 6. Sex 1 ☐ M | 20X F | | last birthda Yrs. | Months | | Hours | | 8. Date of Bi | ay, Year) | | hplace (State or F untry) |
| H | 577-30- Usuet Residence of | | | | 71 | | | l | | | Jan. 2 | , 1928 | Was | hington, |
| | 10a. Stete | 10b. County | | | 10c. Cit | y, Town or | Location | | | | | | | 10d. Inside City |
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| | James | Franc | is E | Babbing | gton | | | | Do | oroth | y Rita | a Harri | İs | |
| | 19e. Informent's No | eme/Reletionsh | ip (Type, I | Print) | | 19b. Me | iling Addres | s (Street | and Numl | ber or Rur | al Route Numb | ber, City or Town | n, State, Z | Tip Code) |
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| Medical Certification: To Be Completed by Physician/Medical Examiner | disease or condition resulting in death) Sequentially list colf any, leeding to in cause. Enter Unde Cause (Disease or that initiated events resulting in deeth) Part II. Other significance of the control of the cause (Disease or that initiated events resulting in deeth) Part II. Other significance of the cause of | Inditions, namediate orlying linjury states the state of | ral Viency Dise Hospinot be letton lot be le | Anoxia Gastro Gastro uting to death Vascula y ease it is input 28e. Place of In (Month, D 28e. Place of In building, e an: To the besis on the basis on manner's | Due to (or a Brain Due to (or a Brain Due to (or but not resear Discount Due to (or but not resear Discount Dis | or as a consist in Dam or as a consist in all | ient 3 D of M street, fector ath occurred investigation e, Print) | cause gives a ca | 26. Place in the p | oce of Deal | 24a. Wesperfill 1 Check only ome 5 Res 28d. Describe 28f. Location City or To | Yes 2 No s an autopsy formed? Yes 2 No one) sidence 8 0 how injury occur (Street and Nun own, Stele) c cause(s) end n date end plece 29d. Date sign April | ontribute 3 🖄 Pr 24b. \ \frac{1}{2} \text{ther (Specurred)} manner as and dua \text{manner as and dua } \text{manner (Monti)} | 1 Week 12 Days 12 Days 12 Days 14 Days 15 to the cause of robebly 4 Du Were autopsy finewallable prior to completion of cause of death? 1 Yes 2 No. City) Ural Route Numbers stated. |

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State of Maryland / Department of Health and Mental Hygiene 9 9

| | | | | Cei | Tifical | re or i | Death | | | Reg. No. | | |
|---|--|--|--|---|------------------------|-------------------------|---------------------------------------|----------------------|-----------------------------------|---|---|--|
| Physician /Medical | | TTISON | | | | | | | Month APRIL | 2, Day | | 3. Time of Death 9:05 A.M. |
| Examiner | 4a Facility Nama (If not Institution, MANOR CARE OF | | nber) | | | 4 | LARG | | ition of Deat | | NCE GEO | ORGE'S |
| Funeral Director | 5. Social Security Number 578–20–4822A Usual Residence of Decedent | 6. Sex 1 □ M 2 🖾 F | 7. Age (In yrs. k | est birthday) Yrs. | If Unde Months | Days | If Under Hours | Min. | Date of Bir (Month, De PRIL | av. Year) | 9. Birth Cour NOR' | place (State or Foreign ntry) TH CAROLINA |
| deeth with the Maryland ms 23s or 28s-f show crust be notified at neral Director | 10a. State 10b. County MARYLAND PRINCE | GEORGE'S | 10c. City | , Town or Lo | cation | | | | | | 1 | 10d. Inside City Limite 1 ☐ Yes 2 🛣 No |
| or 28 | 10e. Street and Number | | | | 10f. Zip | Coda | | | | | n of What Cou | |
| 23a | 600 LARGO ROAD | | | | | 20774 | | | | | ED STAT | |
| it, or its examine by Fur | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Fo | 2 📉 No | | | | spanic Ori an, Mexicer Specify: | | ify Yes or No can, atc.) | | Race - Americ Black, White, pecify: | |
| ygiene. nor than "natural". nt, tra Medical Ext. | 15. Decedent' (Specify only highest Elementery/Secondery (0-12) | s Education (grade completed) College (1 | -4or 5+) | 16a. Dece (Give life. | kind of wo DO NOT u | ork done ise retired | du <i>ring</i> mos d) | t of working | , | | of Business/In | dustry |
| E S E | 12 17. Father's Name (First, Middle, L HAMILTON MOONE | | | DOMES | IIC Y | VUKKI | 18. Mothe | | First, Middle | | | 77. |
| ie marked eumatic ev | 19a. Informant's Name/Relationsh | | | | | | | | | | own, Stete, Zij | |
| ₩ 64 F | ELLEN RUCKER- | -DAUGHTER | | | | | EN AVI | ENUE, | | | | D. 20772 |
| t: If it | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (Sp | ecity) | Stata | ace of Disponentery, cremetery, cremetery | EM, | CEME' | TERY | | 7-99 | LANDO | VER, | MARYLAND |
| Depertment Important: any Injury phoe. | 21. Signature of Fungral Service L | & Johns | ON | FC | RT L | INCO | | NERAL | | TWOOD | , MARYI | AND 20722 |
| hysician /Medical | 23a. Part1. Enter the disease, or o shock, or heart failure. List o | complications that conly one cause on e | ausad tha daath ach line. | . Do not en | er the mo | de of dyin | ng, such as | cerdiac or | respiratory a | arrest, | | Approximate Interval Between Onset and Death |
| xaminer | Immediate Cause (Final disease or condition resulting in death) | a | | as a conse | | | DIO V | ASCUI | LAR DI | SEASE | 1 | YEARS |
| icien and buriel-transit | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evenits | b | Due to (or | as e consec | quence of) | : | | | | | | |
| nding physicien and use es the buriel-tran | that Initiated events resulting in death) Last | d | Due to (or | as a consec | uence of): | | | | | | | |
| e etter ed for u | Part II. Other eignificant condition | ns contributing to de | eath but not resu | Iting In the u | nderlying | cause giv | en in Part | 1. | 23b. Did | tobacco us | se contribute t | to the cause of death? |
| 00 | | | | | | | | | 1 🗆 | Yes 2K | No 3□ Pro | bably 4 Unknown |
| should should | | | | | | | | an autopsy ormed? | av cc | Vere autopsy findings vallable prior to pmpletion of ceuse i death? | | |
| pege 2 | | | | | | | | | 10 | Yes 2 🔼 | No 1 | □Yes 2□No |
| certificate rector, peg | 25. Was cese referred to medical examiner? | | | | | | | e of Deeth (| (Check only | one) | | |
| h. Atter this funeral di | 1 Yes 2 No 27. Menner of Deeth 1 X Netural 5 Pending 2 Accident investig | Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp. 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? | | | | | | | ify) | | | |
| within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification: | 3 Sulcide 6 Could n 4 Homlcide determine | ot be 28e. Place | of Injury - At ho ng, etc. (Specify | me, farm, st | reet, factor | ry, office | | 28 | | (Street end own, State) | Number or Run | ral Route Number, |
| in 24 hour he Funer pletely fills edical | | Physician: To the xaminer: On the ba end mann | | | | | | | | | | |
| M M | 29b. Signature and title of certifiar | show | 019 | MI | | D: | | 08 | | 29d. Date | signed (Month, | Day, Year) |
| (3) | 30. Name and address of person w | M.D. 14 | e of death (Item | | | - | 222) BOW | VIE, M | IARYLA | ND 20 | 715 | |
| State Registrar | 31. Date filed APR 0 6 19 | 99 32/19 | egistrer's Signet | ure 8 | 1 | | | | | | | |

Registrar

28/11/23 11/48

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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:25 pm ANNABELL 04 04 99 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Prince George's Manor Care Health Services Largo If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 K Months 577-12-1297 78 Yrs February 25, 1921 South Carolina Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d Inside City Limits ns 23a or 28a-f show 1 Yes 2 No Directo Maryland Prince Georges District Heights 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 6800 Atwood Street, #4 20747 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No if Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after dea nent of Health and Mental Physiene. Int: if item 27 is marked other than "naturel", or items ury or other traumatic event, its Medical Example. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, atc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: by Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Private 8th House Wife 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Unknown Lilliebell Dubose 19b. Matting Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Carol Watkins/Daughter 4013 91st Avenue, Springdale, Maryland 20774 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition itery, cremetory or other place) 04/09 1 Burial 2 Cremation 3 Removal from State Harmony Mem. Park Cemetery Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) 1999 Landover, Maryland 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 enc 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or he in the fluore. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final STAPHOLOCOCUSS ENDOCARPITIS NEEKS disease or condition resulting in death) **Examiner** Due to (or es a consequence of): RENAL F AILULE NEENS Examir tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) and DIABETES Division of Vital Records, P.O. Box 68760. physician EARS Physician/Medical g Due to (or as a consequence of): 2 SECTENSION TRARS ESSANTIAL ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown BEMENTI ZHMRIRS þ 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 TYes 1 ∏ Yes 2 ∏ No certificate 25. Was cese referred to medical examiner? 89 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 설 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Affer 1 Natural 2 Accident 5 Pending if or Attending I after desth. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month) 29b. Signature and title of certifier 29c. License number 30 Marie and address of be son who completed cause of death (Item 23a) (Type, Print) DONE 22. Registrar's Signeture 31. Date filed (Moth, Day, Year) AFR 0 6 1999 State

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month April 2, Dey 1999 **Physician** 3:20 am Terry L. Moatz /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Dey, Year) Aug. 15, 1 If Under 1 Year | If Under 24 Hrs. 6. Sax Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) Min 1□M 2☑F Months Days Hours 72 Yrs. 1926 Massachusetts 578-28-3796 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6619 22nd Place 20782 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Executive Assistant Banking 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Albert J. Fortin, Sr. Eva Goulet 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6619 22nd Place, Hyattsville, Maryland 20782 Linda E. Mahoney - Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 04/06/99 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 Constance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Last alic Physician/Medicai Dua to (or as a consequance of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of cause of deeth? 2 19 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitai; Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Minpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel Injury 5 Pending 1 TYes 2 □ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. 29b. Signature 29c. Licensa number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) James W. Harding, M.D. 7525 Greenway Center Drive #316, Greenbelt, MD 20770

0 State

Registrar

Funeral

Director

"natural", or items 23a or 28a-f show soical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiena. Important: If fram 27 is marked other than "naturel", or items 23a or 2 and 1 jury or other traumatic event, the Medical Example and DAGE.

Physician /Medical

Examiner

physician end the burial-trensit

attending p

signed by the a

is certificate has b

this funeral

After

n 24 hours after ne Funeral Direct pletaly filled in b

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death.

or Attancation of the original

within 2 To the

The law requires that the death certificate be executed

Attanding Physician:

Hospital

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

the Maryland

31. Dete filed (Month, Dey, Year) 32. Registrer's Signature APR 0 6 1999



1 3 1 15 15

| | 1. Decedent's Name (First, Middle, | | 29 cr | Certifica | 110 01 | Doutin | 2. Dete of De | Reg. No. ath | 3. Time of Death | | | |
|---|---|---|--|------------------------|-----------------------------------|---|---|---|---|--|--|--|
| n | Henrietta | McNair | | | | | Month April | Day | 1999 9:30AM | | | |
| al er | 4a Facility Neme (If not institution, | | | | | | Location of Death 4c. County of Death | | | | | |
| | 13304 Kever | ton Drive | | | | Upper Ma | | | ce George's | | | |
| | 577-26-1795 | Sex 7. Age 1 M 2 1 T F | (In yrs. last bi | | fer 1 Yeer s Days | | 8. Dete of Bir (Month, Da Aug • 1 | 1918 | 9. Birthpiaca (State or Foreign Country) North Carolina | | | |
| - | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | vn or Location | | | | | 10d. fnside City Limits | | | |
| מממו | Maryland Prince | George's | | | Mar1 | boro Mi | tchellvi | lle | 1 ☐ Yes 2 ☐ No | | | |
| - | 10e. Street and Number | | | | Zip Code | 20721 | | | /hat Country? | | | |
| | 1005 13304 Keverton | Arbor Park | Place | | _ | 20721 | | United | States | | | |
| | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedent E Armed Forces? | | | cedent of I becify Cub 2 No | Hispanic Origin? (Span, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | - 14. Race Biac | a - American Indian, k, White, etc. African | | | |
| | 15. Decedent's (Specify only highest of | | 168 | Decedent's Us | sual Occup | pation | orkina | 16b. Kind of Bu | siness/Industry | | | |
| | Elementary/Secondery (0-12) | College (1-4or 5- | +) | life. DO NOT | | during most of wo ed) iinistrat | | Corre | rnmant | | | |
| - | 17. Father's Name (First, Middle, La | st) | | | Auil | | | | | | | |
| | McLain Aber | | | | | | | | | | | |
| 1 | 19e. Informant's Name/Relationship | | 19 | b. Mailing Addre | ss (Stree | | | | Stete, Zip Code) | | | |
| 1 | Janet M. Vernon | - Daughter | | 1005 Art | oor P | ark Plac | e, Mitch | ellville | e, MD 20721 | | | |
| | 20a. Method of Disposition 1 Denial 2 Cremation 3 | □ Bomovei from State | cemete | of Disposition (A | r other pla | | Dete | 20c. Location - | City or Town, Stete | | | |
| | | | Linco | oln Memo | orial | Cem. | 4/9/99 | Suit] | Land, MD | | | |
| 21. Signature of Funeral Service Licensee 22. Name and Address of 4001 Benni | | | | | | | | 10g. Citizen of What Country? United States | | | | |
| 1 | 23a Part Enter the disease, or co | mplications that caused in one cause on each line | the death. Do | not enter the m | ode of dyl | ing, such as cardia | c or respiretory e | rrest, | Approximate interval Between | | | |
| | Immediate Cause (Final disease or condition resulting in deeth) | Conge | stive l | Heart Fa | | e | | | Onset end Deeth | | | |
| 1 | | | | consequence of | | | | | | | | |
| | Sequentially list conditions | b | | consequence o | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | | | | | | | | | | | |
| | Ceuse (Disease or Injury that infiltated events resulting in deeth) Last | c | Due to (or es e consequence of): d | | | | | | | | | |
| 1 | Part fl. Other significant conditions | contributing to death but | t not resulting | in the underlying | o cause o | iven in Part I. | 23b. Did | tobacco use cor | ntribute to the cause of death? | | | |
| 1 | | | | m are arraerly m | g outloo g | | | | 3 Probably 4 Unknown | | | |
| Completed by Physician/M | Osteo Arthriti | S | | | | | . | | | | | |
| | | | | | | | 24a. Was perfe | an autopsy ormed? | availeble prior to completion of cause | | | |
| | | | | | | | 10 | Yes 2 No | 1 ☐ Yes 2 ☐ No | | | |
| ŀ | 25. Wes case referred to medical examiner? | | | | | 26. Place of De | eath (Check only | one) | | | | |
| ŀ | 1) Yes 2□ No | Hospitai: 1 fnpatier | | • | DOA | | T | | er (Specify) Group Hom | | | |
| Certification: To | 27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigat | | Year) 28b. | Time of injury M | 28c. Inju Wo | ury et ork?] Yes 2 No | | 28d. Describe how injury occurred | | | | |
| | 3 Suicide 6 Could not determine | 28e. Place of Inju building, etc. | ry - At home, f (Specify) | arm, street, fact | ory, office | | 28f. Location (City or To | Street and Numb wn, Stete) | er or Rural Route Number, | | | |
| | | | | | | | | | | | | |
| | | | and manner stated. 29b. Signeture and title officertifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | | | |
| 5 | (Check only 2 Medical Ex | | led. | 2 | 29c. Licen | nse number | | 29d. Date signed | d (Month, Day, Year) | | | |
| Medical | (Check only 2 Medical Ex | and manner stat | | | | 00051473 | | | d (Month, Day, Year) | | | |

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State of Maryland / Department of Health and Mental Hygiene

| | | | | Certifica | ate of | Death | | Reg. | No. | | 0100 |
|--|--|---|----------------------|---|---|------------------------------|--|---------------|------------------------------|-------------------------|---------------------------------------|
| | 1. Decedent's Name (First, Middle, | Last) | | | 17 | | | of Death | Day | Year | 3. Time of Death |
| Physician | Stanley | Metalitz | | Apr | | | 999 | 11:50 PI | | | |
| /Medical Examiner | 4a Facility Name (If not institution, | | | | | 4b. City, Tov | wn, or Location of | | 4c. County of | | 11.50 11 |
| Examiner | 1131 Universit | v Blvd. | | | | Silv | er Spri | ng | Mont | aom | erv |
| Formati | | | e (In yrs. last birt | | ler 1 Yeer | if Under 2 | 24 Hrs. 8 Date | of Birth | | | |
| Funeral Director | 099-03-6215 | Sex 7. Ag | | Yrs. Month | s Days | Houre | Min. (Mon Dec | h, Day, Ye | 1917 | Coun | lece (Stete or Foreign try) ew York |
| | Usual Residance of Decedent | | 01 | | | | Dec | .) | 1911 | IA | EM TOTY |
| land | 10a. State 10b. County | | 10c. City, Town | or Location | | | | | | 1 | Od. Inelde City Limits |
| Aary Or | MD Monto | | 0.57- | | | | | | | | 1 ☐ Yes ŽÍNo |
| vith the Mar or 28a-f si | 10e. Street and Number | gomery | STIV | rer Sp | I I I I C | 3 | | 100 | Citizen of W | hat Coun | tn/? |
| Di No vith | | 77. 7 | | 101. 2 | Lip Cooo | 000 | 7.0 | log. | | nat Court | ay r |
| ath 123 | 1131 Universit | uh. | | | | 209 | | | USA | | T. L. M. L. |
| of the death virther death virther must make must must must must must must must must | 11. Maritel Status | 12. Was Decedent Armed Forces? | | 13. Was Dec | cedent of locality Cut | Hispenic Orig en, Mexicen | gln? (Specify Yes i, Puerto Rican, et | or No- c.) | 14. Race Bleck | - Ameno , White, | |
| 5-0020 72 hours after death with the Maryland natural; or itama 23a or 28a-f show area Examiner must be notified at seed by Funeral Director | 1 Never Married 2 Married | 1 N Yes 2 □ f | 101943− | 1 ☐ Yes | ZV No | Specify: | | | Specify: | Wh | ite |
| 215-0020 thin 72 hours at e. an "natural", or Modest Exam | 3 ₩ Widowed 4 Divorced | | 1946 | | 41 | | | | | **** | 100 |
| 21215-0 ed within 72 ho regions. In the waters. | 15. Decedent's (Specify only highest | Education | 16a. | Decedent's Us (Give kind of | sual Occu | petion during most | t of working | 160 | . Kind of Bus | iness/Inc | dustry |
| within within than the way | Elamantary/Secondary (0-12) | College (1-4or 5 | 5+) | iffe. DO NOT use retired) | | | | | | | |
| 212 withinglene. | | 5+ | Te | chnic | al V | Vrite: | r/Edito | r Fe | deral | . Go | vernment |
| be fire the state of the state | 17. Fether's Name (First, Middle, La | st) | | | | 18. Mothe | r's Name (First, A | liddle, Mai | den Sumame |) | |
| lan ked o | Robert Metal: | itz | | | | Blan | nche Sc | hind | lling | | |
| Maryland d2 should be fig th and Mental Hy T is merked oth traumatic event | 19a. Informant's Name/Relationship | (Type, Print) | 19b. | Mailing Addre | Addreae (Straet and Number or Rural Route Number, City or Town, | | | | | | Code) |
| and 2 mailth a nath a er tran | Steve Metalit | z/Son | 80 | 07 Pa | rk (| Crest | Dr., S | ilve | r Spr | ing | , MD |
| the Hear | 20a. Method of Disposition | | 20b. Place of | Disposition (A | ame of | | Data | | . Location - C | | |
| altimore mil. Pages 1. pariment of He portant, if item y injury or oth | Wurial 2 ☐ Cremation 3 | | | y, crematory o | | | 4.4- | | | | |
| The state of the s | Donetion 5 Other (Spe | 1 | Mt. I | | | | ry 4/5/ | 99 A | delph | 11, | MD |
| Sall separation my in | 21. Signature of Fungral Service Lie | chosee | / | 22. Neme | end Addr | ess of Facility | Takom | a Fu | neral | Но | me |
| m gores | 450 | Man | 1 | 254 | Carr | coll s | St., Wa | | | | 20012 |
| | 23a. Part1. Enter the disease, or co | emplications that caused | the death. Do r | | oda of dy | ing, such as | cardiac or respira | lory arrest, | | | Approximate Interval Between |
| Physician | shock, or heap failure. List or | ny ona cause on each in | ne. | | | | | | | | Onset and Deeth |
| /Medical | Immediata Cause (Final | 10 | 10. | | | 1 1 | V . | | | 14 | de of |
| Examiner | disease or condition resulting in death) | a flac | all u | ncer, | nex | una | <i>MC</i> | | | 1 | Thomsky |
| i | | | Due to (or as a | consequange o | of): | | | | | | |
| executed in end intransit | | b . | | | | | | | | i | |
| x 68760, ertificate be executed ing physician end is es the burial-transit Medical Examir | Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events | | Due to (or as a o | consequence | f): | | | | | i | |
| 68760, ificate be expression as the burial edical E | causa. Entar Underlying Cause (Disease or injury | c | | | | | | | i | | |
| x 6876 entificate be ling physicia e es the bu | that initiated events resulting in daath) Last | | Due to (or as a c | onsequance o | f): | | | | | | |
| 5 00 5 | | | | | | | | | | 1 | |
| Sox th cer endin r use | | d | | | | | | | | 1 | |
| P.O. BO at the death c 1 by the attencetached for us Physician | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributions | | | | | | | | | tribute to | the cause of death? |
| that the deed by the a detached f | | | | | | | 1 Yee | | | bably 4 Unknow | |
| " = 90 > | | | | | | | | | | | |
| | | | | | | | 24a | Was an a | utopsy | 24b. W | ere autopey findings |
| | | | | | | | | performed | d? | CO | ailable prior to mpletion of cause |
| I Rec | | | | | | | | | | 10 | death? |
| = F # a 0 | | | | | | | | 1 🗆 Yes | 2 No | 1 [| Yes 2□ No |
| 0 0 0 | 25. Was cese referred to medical examiner? | | | | | 26. Place | of Death (Check | only ona) | | | |
| nysicie nysicie nis cert i direct | 1 Yas 2 No | Hospital: | nt 2 ER/Ou | tpatient 3 | DOA O | ther: 4 Nu | ursing Home 5 | Residenc | e 6 DOthe | r (Specif | y) |
| Physerthis erald | 27. Manner of Death | 28a. Date of Inju | | ime of | 28c. Inju | ury at | 28d. Des | cribe how | injury occurre | ed | |
| ding ding th. | 1 ☑Natural 5 ☐ Panding 2 ☐ Accident Invastiga | (Month, Da | y rear) | njury M | | Yes 2 | No | | | | |
| Division of the diagram of the diagram of the funer death. So the diagram of the diagram of the funer death of the funer death of the funer of the diagram of the funer of the diagram of | 3 Suicide 6 Could no | t be One Piece of Ini | ury - At home, fe | rm. street, fact | ory, office | | 28f. Loca | tion (Stree | et and Numbe | er or Rura | Il Route Number, |
| Oiv Oire | 4 Homicida datarmin | building, at | c. (Specify) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | .,, | | City | or Town, S | State) | | |
| | 000 00000000000000000000000000000000000 | | | | | | | | (1) | | |
| ne Hosp n 24 hou ne Fune pletely fil | (Check only 2 Medical Ex | Phyalcian: To the best caminer: On the basis of | examination en | , death occurred/or investigati | on, in my | opinion, daa | th occurred at the | tima, data | e(s) and mar and placa, a | nner as s ind dua to | tated. tha causa(s) |
| To the To the Comple | one) | and manner sta | ated. | | | | | 1 001 | 5 . L k | /A A AL | De Mari |
| O N | 29b. Signature and alle of certifier | 1.1 | // | ٨ : | Sec. Licen | ise number | , / . | 29d. | . Date signed | (wonth, | Day, 1981) |
| (-) | Al Chileolin | & reals | 1-10) |) | 021 | 280 | 1/mh | A | 15/ | 19 | |
| (0) | 30. Name and address of person w | to domptleted cause of d | (Itam 23a) | Type, Print) | | -0 / | (") | 1 | 10/1 | - | |
| (10) | Nicholas Roge | | | | ecto | 711+ 2 | ye. Sil | ver | Sprir | na | MD |
| State | 31. Date filed (Month, Day, Year) | | ar's Signature | , 001111 | | Jul A | y C . U 1 1 | ACT | PATTI | 71 | - 1-2 |
| Registrar | APR 0 5 199 | | w A | 1 | | * | | | | | |

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flering a see projection. There

A Company Company

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year Zoila M. Martinez Apr 1,1999 10:31pm 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Deys Months 1 M 200 Yrs. 64 Salvador 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Montgomery Kennington 10f. Zip Code 10g. Citizen of What Country? 20895 U.S.A.

Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

14. Race - American Indien,

Specify: Hispanic

Black, White, etc.

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

N/A

18. Mother's Neme (First, Middle, Maiden Sumame)

Rosalia Navarro 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

3421 - W. Univ. Blvd., #203 Kennington, Md. 20895

28a-f show must be notified at "natural", or flerns 23s or Baltimore, Maryland 21215-0020 Hyglens. permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important. If them 27 is marked other any injury or other treumstic event, the

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

Examiner physician and the burial-transit Physician/Medical 950 þ Completed peen 165 certificate Be Certification: To edicai

certificate be executed Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

2

State Registrar

Director 3417- W. University Blvd. #302 Funeral 11. Meritel Stetus 1 Never Merried 2 Married þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 6th 17. Fether's Neme (First, Middle, Last) Be Heriberto Assencio 19e. Informent's Neme/Reletionship (Type, Print) Antonia Garcia/Daughter 20e. Method of Disposition Immediate Cause (Finel disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

1 Yes 2 No

27. Manner of Deeth

1 Naturel

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signeture and title of aprtifice

Tako L. Sato MD

3 Suicide

29e. Certifier

5. Social Security Number

578-85-0472

10e Street and Number

10a Stete

MD.

Usual Residence of Decedent

12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2000 No
If Yes, Give
Yeer or Detes:

College (1-4or 5+)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 X Burial 2 Cremetion 3 Removel from Stete Maryland National Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 4/5/99 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Hackett's Funeral Chapel, Inc. Tackid 814- Upshur Street, N.W. 23e. Pert1. Erfter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Due to (or as a consequence of):

Due to (or as a consequence of): HUURS DAYS ARDIAL Due to (or es e consequence of) 3 DAW tury Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 0 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one)

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year) RORIL 2/1999

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospitel:

5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

14816 Physicians Lane Suite 152 Rockville Md 20851

31. Dete filed (Month, Dey, Year)

APR 0 5 1999

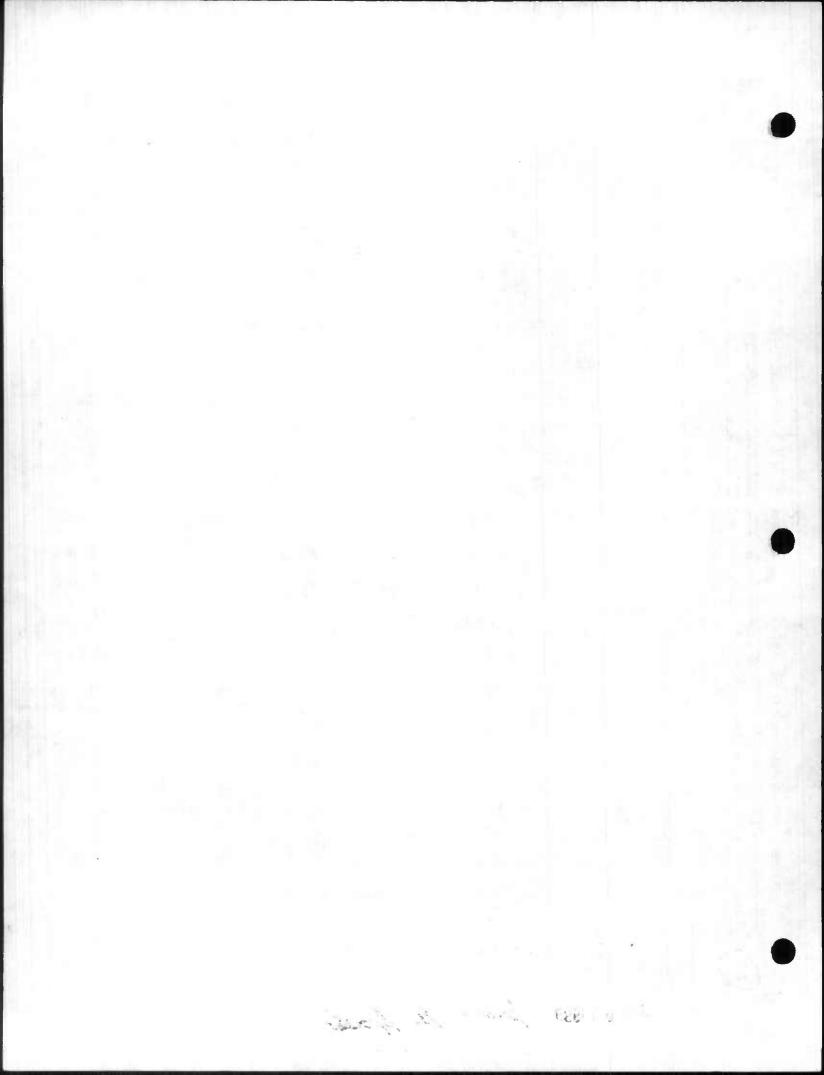
32. Registrer's Signeture

1 Inpatient 2 ER/Outpatlent 3 DOA

28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

28b. Time of

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State of Maryland / Department of Health and Mental Hygiene

| | | Certificate of | of Death | Reg. N | lo. | 3 5 5 | | |
|---|--|--|--|--|--|---|--|--|
| | Decedent's Name (First, Middle, Last) | | 2. | Dete of Death Month | Dey Year | 3. Time of Death | | |
| Physician /Medical | Jimmie L. Moorer, Sr | • | A | | 1999 | 12:01am | | |
| Examiner | 4e Facility Name (If not institution, giva street and number) | | 4b. City, Town, or Local | tion of Deeth 4 | Ic. County of Deeth | | | |
| | Prince George's County Hos | pital | Cheverly | | Prince Ge | orge's | | |
| Funeral Director | 5. Sociel Security Number 6. Sex 7. Age (250-58-1004 | (In yrs. lest birthdey) If Under 1 Young Months De | ys Houra Min. | Date of Birth (Month, Day, Yea IOV . 22, | 9. Birthp Cour 1939 Sout | olece (State or Foreign otry) h Carolina | | |
| and land | | Oc. City, Town or Location | | | 1 | 0d. Inside City Limits | | |
| the Mary se-f eh oured | Maryland Prince George's | Capitol Heigh | | 100.0 | Distance of Milest Court | 1√2 Yas 2 No | | |
| Uniter deeth with the Mainter rems 23s or 28e-1 entrer must be notified in Function Function | 1312 Karen Blvd. | 10f. Zip Coo 2074 | 3 | Un | ited Stat | es | | |
| by | 11. Maritel Stetus 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedant Ev. Armed Forces? 1 □ Yes 2 □ No If Yas, Give Yeer or Detes: | ar in U,S. 13. Wes Decedent if Yes, specify € | of Hispenic Origin? (Specif Cuben, Mexicen, Puerto Ric No Specify: | y Yas or No- en, etc.) | ean Indian, etc. | | | |
| Baltimore, Maryland 21215-UU20 permit. Peges 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Evan pace. To Be Completed by F | 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondery (0-12) Collega (1-4or 5+) | 16e. Decedent's Usuei Oc (Give kind of work do iife. DO NOT use re Truck Drive | one during most of working stired) | 16b. | Kind of Bualness/Inc | | | |
| Maryland 212 d 2 should be filed with h end Mental Hygiene. 7 is merked other that traumatic event, that | 9th 17. Fether's Neme (First, Middle, Last) | | 18. Mother's Neme (F | | an Sumeme) | | | |
| To To | Dave Moorer | | | latthews | | | | |
| 2002 | 19e. Informent's Name/Reletionship (Type, Print) Carrie Moorer / Wife | | reet e <i>nd Number</i> or <i>Rural F</i> Slvd. Capitol | | | | | |
| Baltimore, IV permit. Peges 1 end; Department of Health Important; If item 27 I any Injury or other tr. once. | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) | 20b. Piece of Disposition (Neme of cemetery, cremetory or other Lincoln Memoria | plece) 4/9 | 1 | itland, M | | | |
| ifficate be executed Wedical Examiner Tedical Examiner | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Du d. | a daath. Do not antar the mode of the to (or es e consequence of): a to (or es e consequence of): a to (or es a consequence of): | er S. Pope Fu lboro Pike/F dying, such as cardiac or r | orestvil | le, Maryl | Approximete Intervel Between Onset end Deeth | | |
| dS, P.O. BOX ires thet the death cert signed by the ettendin d be deteched for use d by Physiclan/N | Part II. Other significant conditions contributing to death but of Renal Farlure He | | idrome | 23b. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 194 | | | | |
| Physician: The law requires the cartificate has been signed in director, page 2 should be cartificate. To Be Completed by | Renal failure/He, Stophylococcal sepsis | | | 24a. Wes en au performed? | ? av | ere eutopsy findings vailable prior to empletion of cause death? | | |
| r Vital nectivations to securificate hes big director, pege 2 s | | | | 1 ☐ Yes | 210 11 | □Yas 2□ No | | |
| delan: The certificate rector, peg | 25. Wes case referred to medice! | | 26. Place of Deeth (| Check only one) | | | | |
| Physician: rihis certific nal director. | exeminer? 1 Yaa 2 No Hospital: 1 Inpatianf | 2 ER/Outpatient 3 DOA | Other | | 8 Other (Special | fv) | | |
| To the Hospital or Attending Physical To the Hospital or Attending Physical To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To | 27. Manner of Daeth 1 Naturel 5 Pending (Month, Day Y 2 Accident Investigation | /eer) 28b. Time of 28c. | Work? 1 ☐ Yes 2 ☐ No | | escribe how Injury occurred | | | |
| DIVISION Lal or Attending 18 effer death. 19 Director: Affer 19 in by the fune 19 certification | 3 Suicide 6 Could not be determined 28e. Plece of Injury building, etc. (| y - At home, farm, street, factory, off (Specify) | ice 28 | t. Location (Street City or Town, Ste | Location (Street end Number or Rural Route Number City or Town, Stete) | | | |
| To the Hospital or Attending R within 24 hours stert deaths To the Funeral Director: After completely filled in by the funer Medical Certification: | 29e. Certifier (Check only one) 1 Cartifying Physician: To the best of roone) 1 Cartifying Physician: To the best of roone end menner stele- | xaminetion end/or Investigation, in r | | | | | | |
| To th To th comp | 29b. Signature and title of-certifier | 29c. Lic | 29c. Licensa number 29d. Date signed (Month, Day, Year) | | | | | |
| | 1 West un | es D | 43662 | 4 | 4/2/99 | | | |
| (3) | 30. Neme end address of person who completed ceuse of deel WMM+M BUUCE - 300/ | | , Cheverly | | 20785 | | | |
| State Registrar | 31. Dete filed (Month, Day, Year) APR 0 5 1999 | | | | | | | |

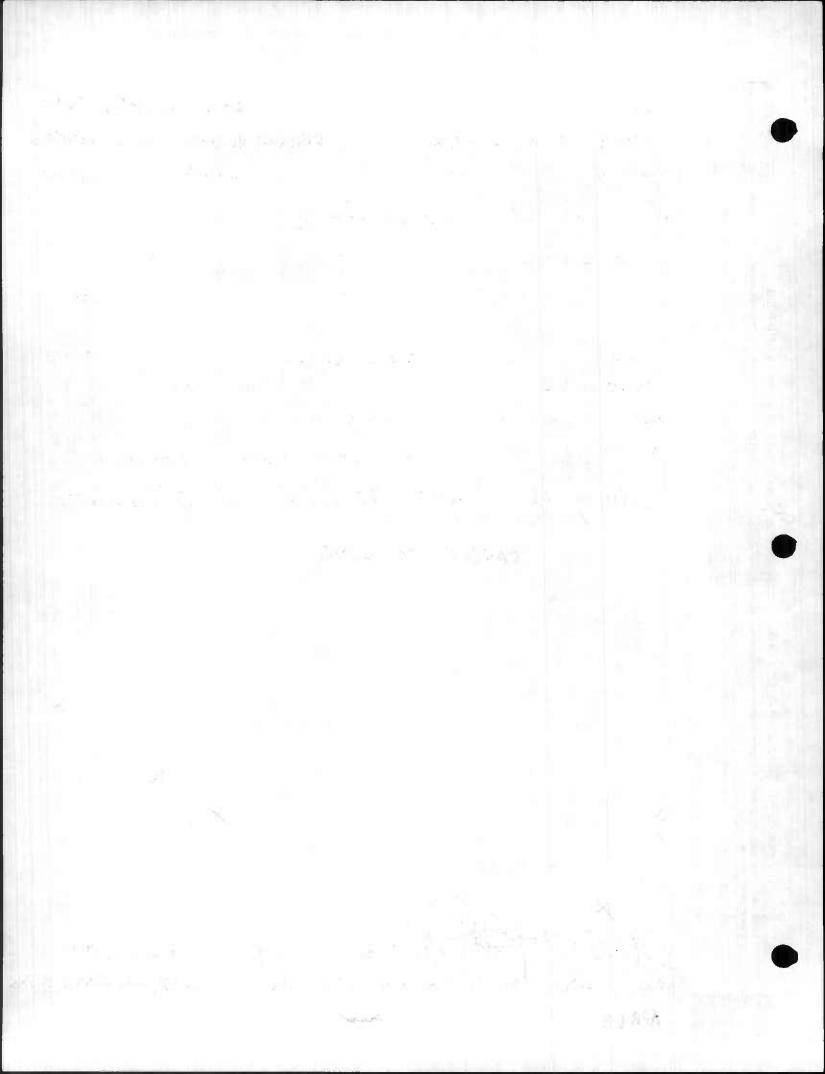
DHMH 16 Rev 6/95

Registrar

- I I Same Section 1

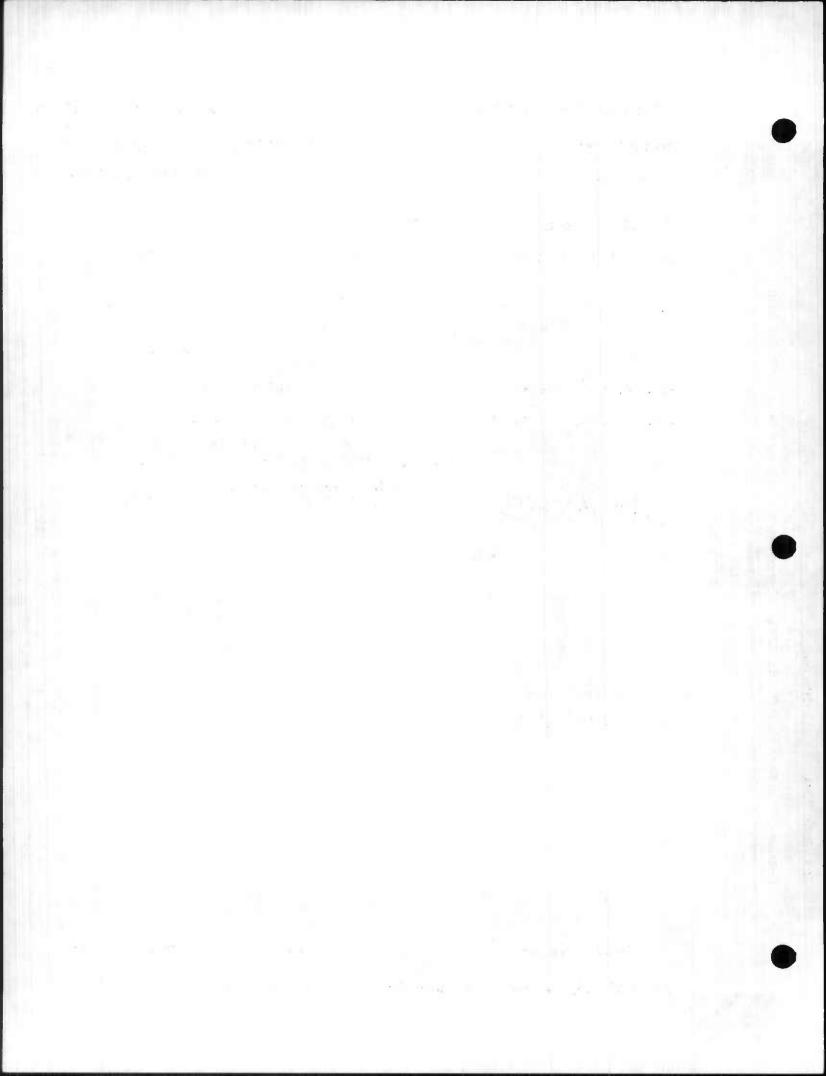
State of Maryland / Department of Health and Mental Hygiene Q

| | | | | | Cei | rtificate | of L | Death | | | Reg. No. | | |
|---|--|--|--|-----------------------------------|--|------------------------------------|---------------|---------------------------|----------------------------|--|------------------------------|--|---|
| Physician | 1. Decedent's Nama (First, Mi | ddla, Last) | | 1019 | | | | | | 2. Data of D Month | eeth Day | Year | 3. Tima of Death |
| Physician /Medical | CLAUDE IRV | ING MO | CCLAIN | | | | | | | APRIL | 05 | , 1999 | 1016 |
| Examiner | 4a Fecility Nama (# not institu 2522 | | | AVENC | IE | | | | | cation of Dea HEIGH | | Ounty of Death | GEORGE'S |
| uneral rector | 5. Sociel Security Number 577–22–0298 | 6. Sex | M 2□ F | Aga (fn yrs. la: | st birthday) Yrs. | If Under 1 \ | ear ays | If Under Hours | | 8. Data of B (Month, D 6/10/2 | irth av. Year) | 9. Birth | place (State or Fore intry) Carolina |
| | Usual Rasidanca of Decedant | | | | | | | | | | | | |
| Example court be notified at by Funeral Director | Md. P | .G. | | | istrict Heights | | | | | | | + 7 | 10d. tnsida City Limi 12 Yas 2 ☐ h |
| Te pa | 10e. Street and Number | | | | 10f. Zip Coda | | | | | | 10g. Citize | on of What Cou | intry? |
| al B | 2522 Senator | Aveni | ue. | | 20747 | | | | | | | U.S.A. | |
| by Funeral Director | 11. Maritai Status 1 Navar Married 2 N | 1 larried | 2. Was Decedar Armad Forca: 1 ☐ Yes 2.2 If Yas, Giva Yaar or Datas | s? No | | Was Decedant If Yas, specify | of Hi Cube | | | ecify Yas or N Rican, atc.) | | I. Race - Amar Bieck, White Specify: B | |
| ted b | | dant's Educ | ation | s. | 16a. Dece | dant's Usual O | ccupa | ation | et of worki | na | 16b. Kind | d of Business/fi | ndustry |
| Completed | Elementery/Secondary (0-1) | | Collega (1-4o | or 5+) | lifa. DO NOT usa ratired) Forklift Operator | | | | | ng . | U | .S. Gov | vernment |
| Be C | 17. Fathar's Nama (First, Midd | lla, Last) | | | TOLK | | | | ar's Name | (First, Middle | | | |
| ToB | Robert Mc | Clain | | | | | | | Lau | ıra Pei | cing | | |
| T | 19a. Informant's Name/Ralati Joyce E. Tate | | | | 19b. Meiling Address (Streat and Number or Rural Same as # 10 above | | | | | | | Town, Stata, Z | ip Coda) |
| | 20a. Mathod of Disposition | n 2 🗆 n | amovei from Chai | cor | ce of Dispo | sition (Nama matory or othe | of r plec | e) | | Date | 20c. Loca | ation - City or T | own, Stata |
| | 4 Donation 5 Other | | MILONAL HOM STO | Har | mony | Mem. Pa | ark | 4, | /10/9 | 99 | Land | lover, Mo | d. |
| à | 21. Signatura of Funaral Serv | ice License | 6 | | 22 | . Nama and A | ddras | s of Fecili | ity | | | | |
| Buck | Xanu | 11 | 1 | ratt | - | H.S.W | ash | ingt | on # | Sons (| Co., In | C. | 20010 |
| | 23e. Part 1. Enter the disal e, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failur. List only one cause on each line. | | | | | | | | | | | n.,D.C | Approximate |
| nysician Medical xaminer | shock, or heart failure. | ist only one | e causa on aach | ina. | DO HOL AIN | ai ina moua o | i dynii | y, such as | Cardiac C | n respiratory | arrast, | 1 | Intarvai Between Onsal and Death |
| | | | | | | | | | | | | 1 | Orisal and Death |
| | tmmediata Causa (Final disaese or condition rasulting in death) e. CANCER OF LUNG Dua to (or as a consequence of): | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| ام ا | | | | | | , | | | | | | | |
| Ē | Convention, list conditions | uantielly list conditions. Dua to (or as a consequence of): | | | | | | | | | | | |
| Examiner | Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | Dua to (or a | as a consec | qualice oi). | | | | | | 1 | |
| | Causa (Disaasa or injury that initiated avants | c . | | Distriction | | | | | | | | - | |
| Medical | resulting in daeth) Lest | | | Due to (or a | is a conseq | uance of): | | | | | | | |
| | | | | | | | | | | | | | |
| Physician | Part II. Other significant cond | ittons cont | ributing to death | but not rasuit | ing in the u | ndarlving caus | a diva | an in Part | l. | 23b. Did tobacco use contribute to the cause | | | |
| hys | | | • | | | ,,,,,, | | | | | obably Wunkn | | |
| by Pi | | | | | | | | | | ,,, | Yes 2 | | |
| | | | | | | | | | | 24e. Wa | s an eutops | y 24b. V | Vera eutopsy finding |
| Completed | | | | | | | | | | per | lormed? | 0 | vailable prior to completion of cause of death? |
| dmo | | | | | | | | | | | lwar a N | | |
| | | | | | | | | | | | Yas 2 | 100 1 | ☐ Yes 2☐ No |
| Be | 25. Wes casa rafarrad to med axaminer? | - | n snitai: | | | | Oth | ac. | | (Check only | | | |
| 10 | 1 Yes 2 No | THO . | ospitai: | | R/Outpatier | | Otha | 4 🗆 N | | | | Othar (Spec | eify) |
| | 27. Manner of Deeth 1 2 Natural 5 ☐ Per | ding | 28e. Data of In (Month, L | Day Year) | 8b. Tima o Injury | | Injun Work | | | 28d Oa scribe | how injury | occurred | |
| Certification: | 2 ☐ Accidant inv | stigation | | | | М | 10 | Yas 2□ | No | | | | |
| tiff | 3 ☐ Suicida 6 ☐ Col 4 ☐ Homicida dat | id not be arminad | 28a. Place of i | Injury - At hom atc. (Specify) | ne, farm, sti | eat, factory, o | ffice | | | | (Streat and own, Stete) | Number or Ru | ral Route Number, |
| Cer | | | - I am gi | , | | | | | | | | | |
| edical | 29e. Certifiar 1 Certification (Check only one) Medic | ying Physi ai Examin | ician: To the bes ar: On the basis and mannar | of examination | edge, deatl on and/or in | n occurred et t vastigation, in | he tim | e, date er pinion, daa | nd piace, a ath occurre | and dua to the ed at tha time | e cause(s) a , date and p | ind mannar as place, and due | stated. Io lhe causa(s) |
| × | 29b. Signattheyand title of gen | gior . | 161 | 10 | 1 | 29c. L | icense | number | | | 29d. Data | signed (Month | n, Day, Year) |
| | × 16000 | 1111 | FU | V d | 110 | MATT | 0 | 779 | 71 | | 1.0 - 1 | | 1906 |
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| state | 31. Dete filed (Month, Dey, Ye | _ | 6 N. A. | strar's Signatu | ra | | | | 1 | | | | |
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| | the Mospital or Attending Physician: The law requires that the death certificate thin 24 hours after cleath. | the Funeral Oirector: After this certificate has been signed by the ettending phys |
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| | | | | | - | | cate of | Death | | Reg. No. | J ! | 3170 |
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| Physician | | Decedent's Neme (First, Midd | fle, Last) | | | | | | 2. Dete of D Month | Dey | Year | 3. Time of Death |
| /Medica | | GERTRUDE VI | RGINIA MO | ORAN | | | | | April | | 19 | 8:00 am |
| Examine | 40 | Fecility Neme (If not Institution | on, give street end | d number) | | | | 4b. City, Town, or I | ocation of Dee | | | |
| | М | emorial Hospi | tal | | | | | Cumber1a | and | A11e | gany | |
| Funeral | | Social Security Number | 6. Sex | | In yrs. lest birt | | Inder 1 Year | If Under 24 Hrs. | 8. Date of B | | 9. Birth | plece (Stete or Foreign intry) |
| Director | | 13 10 9662 uel Residenca of Decedent | 1□ M 2🔯 | F 8 | 0 | Yrs. | nths Deys | Hours Min. | | 5, 1919 | | YLAND |
| death with the Meryland rms 23a or 28a-f show rms that be notified at | | e. Stete 10b. County | / | 1 | 0c. City, Towr | n or Location |) | | | | | 10d. Inside City Limits 1X Yes 2 □ No |
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| it a | 10 | e. Street end Number | | | | 10 | f. Zip Code | | | 10g. Citizen | of What Cou | intry? |
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| or he | an Lane | . Maritel Stetus 1 Never Merried 2 Ma 3 Widowed 4 Divorce | rried Arme | Decedent Evo d Forces? les 2∑ No i, Give or Detes: | er in U,S. | 13. Was Decedent of Hispenic Origin? (Specify Yes, specify Cuben, Mexican, Puerto F | | | pecify Yes or N Rican, etc.) | 14. F E Spe | lleck, White | ican Indien, , etc. HITE |
| 15-00% | 2 | 15. Decede | nt's Education | | 16e. | Decedent's | Usual Occup | pation | | 16b. Kind of | | |
| I 21215-0 led within 72 ho ygjene. her then "neturi rt, I'm Medical | o o | (Specify only higher | | | | (Give kind of life. DO No | of work done OT use retire | during most of world) | king | | | |
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| other vent, be | 17 | Fether's Neme (First, Middle | , Last) | | J.A. | | | 18. Mother's Nam | e (First, Middl | | | |
| Maryland 42 should be filed the and Mentel Hyge traumatic event, | Ď | WILLIAM M. YOU | | | | | | MARGARE | | | | |
| Nen louid | - | | | | | | | | | | | |
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| 1 and 1 and Health Health | | AREN E. MORAN | / DAUGH | TER | | | | IC ST., F | | - | | |
| noi eges ant of t: If It y or o | 20 | 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) REST LAWN MEMORIAL GARDENS | | | | | | | | 20c. Location | | own, State |
| altim nit. Perantiment ortant: Injury | 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility | | | | | | | | | Lavall | , FID | |
| Baltir permit. P Departme Importan eny Injur | | NA M | / | | | SOWEI | RS FUN | ERAL HOME | , P.A. | | | |
| | - | Han III's | ower | > | | 60 W. | . MAIN | ST., FRO | STBURG | , MD 21 | 532 | |
| | 21 | la. Parti. Enter the disease, o shock, or heart failure. Lis | complications to | fat caused the | e death. Do r | not enter the | mode of dyle | ng, such es cardiac | or respiretory | errest, | 1 | Approximete Intervel Between |
| Physician | | | | - | | | | | | | | Onset end Deeth |
| /Medical | | mediate Cause (Final sease or condition | | Senci | | | | | | | | Investe |
| Examiner | resulting in deeth) Due to (or es e consequence of): | | | | | | | | | | | |
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| 60, be executed clean end buriel-trensit | | | | | | | | | | | | |
| 68760, rificete be executed physician end es the buriel-tree | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initialed events Due to (or as a consequence of): | | | | | | | | | | 1 | |
| 68760, ificete be extended by the buriel. | Ca Ce | cause. Enter Underlying Ceuse (Disease or Injury c. | | | | | | | | | 1 | |
| physic the | Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or as e consequence of): | | | | | | | | | | 1 | |
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| death certiff e ettending of for use es | | | | | | | | | | | | |
| that the death ed by the ette detached for | Pe | rt II. Other significant conditi | ons contributing (| to deeth but i | not resulting In | n the underly | Ing cause gi | ven In Pert I. | 23b. Di | d tobacco uee | contributa | to the cause of death |
| P.O at the d by th etache | | Para 1 1 | | 1: care | | | | | 10 | Y88 2□ N | 0 3 Pr | obably 4 Unknow |
| s the sold sold sold sold sold sold sold sold | - | Covoney and | eng an | nase | - | | | | | | | |
| The law requires that the death cert are has been signed by the ettending page 2 should be detached for use Completed by Physicilan/M | 2 | | U | | | | | | 24e. We | s en eutopsy | 24b. \ | Vere eutopsy findings weileble prior to |
| She she | <u></u> | | | | | | | | per | formed? | | completion of cause |
| Has by 20 2 s | | | | | | | | | | _0 | | |
| Vital Re | 3 | | | | | | | | 1 | Yes 2 No | 1 | ☐ Yes 2☐ No |
| ysician: ysician: s certific director, | 25 | . Wes case referred to medical examiner? | | | | | | 26. Plece of Dec | th (Check only | one) | | |
| _ 5 00 | 2 | 1 ☐ Yes 2 ☐ No | | Inpatient | | itpatient 3[| DOA O | her: 4 Nursing H | ome 5 Re | sidenca 6 🗆 | Other (Spec | city) |
| Ono On O | 27 | Menner of Deeth | 28e. D | ete of Injury Month, Dey Y | (ear) 28b. T | Time of njury | 28c. Inju Wo | ry et rk? | 28d. Describe | e how injury oc | curred | |
| Division or Attending after death. Director: After I in by the fune | 100 | 1 Neturel 5 Pendi 2 Accident Invest | rigation | ,, ' | | M | | Yes 2 No | | | | |
| Attending the form of the form | 2 | 3 Suicide 6 Could | nined 286. P | lace of Injury | - At home, fe | rm, street, fa | actory, offica | 281. Location (Street and Number or Rural Rout | | | ral Route Number, | |
| Date of the control o | 5 | 4 Homicide | Ь | uilding, etc. | (Specify) | | | | City or I | or Town, Stete) | | |
| Division or To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: | 29 | (Check only 2 Medical | Examiner: On the | ne basis of ex | caminetion en | e, deeth occu | urred et the till etion, In my d | me, dete end plece | , and due to th | e cause(s) and e, dete end ple | menner as ce, and due | steted. to the ceuse(s) |
| the the | | one) | | menner stete | d. | | | | | | 1 | D 1/ |
| Vithi To the | 29 | b. Signeture and the of certifi | er) | | | | 29c. Licens | se number | | 29d. Date sig | ned (Montl | n, Day, Year) |
| 5 | | 1 July . | me | | | | D 3 | 3280 | | April | G, | 1999 |
| | 30 | . Neme end eddress of person | who completed | cause of dee | th (Item 23e) (| (Type, Print) | | | | - | / | |
| nes | | 1/ | | | | | | o C1 | | MD 21 | E02 | |
| | | Dr. Sunil Gup | | SON HE | | medic | aT_DTG | g., cumb | errand, | בא עוזי | 502 | |
| State Registrar | | APR 0 7 199 | 19 | A CHARLES | 13 | and the same | - est / | | | | | |
| negistrar | | | | | 1 | 1100 | 公司主任 | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 11:12 PM Lola Lorrene Newman 1999 Apri 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Regional Prince George's Hospital aure If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 X F 481-12-3314 76 September 2,1922 Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Greenbelt Maryland Prince Georges 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Ridge Road Apt. 217 20770 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Information Clerk Busing Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wyatt William Kachle Anna Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8425 Blue Stone Ct. Columbia, MD Karin Lorrene Walsh/Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 2 Washington, D.C. 4 Donation /5 ☐ Other (Specify) uneral Service Lice 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.. C 20037 Pa41 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth immediate Cause (Final disease or condition resulting in death) Late onset Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? meemia 1 Yes 2 No 3 Probably 4 Unknown terord induced Cushing Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 anc 2 ANO 1 Yes 1 ☐ Yes 2 No

Physician /Medical Examiner

physician end s the buriel-transit

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After this funeral

a Funeral Director: After details in Property of the Funeral Director: After the fun by the fun

within 24 hou To the Fune completely fi

Attending

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law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

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Certification:

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Physician

/Medical

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Funeral

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Director

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examine must be notified an once.

Baltimore, Maryland 21215-0020

Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 ZiNatural 5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

Hospital:

28b. Time of

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

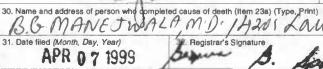
29b. Signature and title of cartifier Jonemale 29c. License number

29d. Date signed (Month, Day, Year)

14201 Lawrel Park Dr Lawrel MD 20707.

Registrar

31. Date filed (Month, Day, Year) APR 0 7 1999



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State of Maryland / Department of Health and Mental Hygiene 00

| | | | • | Ce | rtificate | of Death | | Reg. No. | 2 1 | 0116 |
|--|----------------|--|---|----------------------------------|----------------------------------|--|---|---|---------------------------|---|
| Dhysisi | | 1. Decedent's Name (First, Middla, Last) | | | | | 2. Date of I | Death | Year | 3. Time of Death |
| Physicia /Medic | | Susan Eliza | ineru- | ulli | | | | L 4,1999 | 1041 | 7:00AM |
| Examin | er | 4e. Fecility Name (If not institution, giva s | Heat are a over 15 and | | | | n, or Location of De | | | |
| | | Doctors Communit 5. Social Security Number 6. Sex | | la et hirthday | If Under 1 | | ham 4 Hrs. 8. Dete of t | | | eorges |
| Funeral Director | | | M 212 F 89 | Yrs. | | Days Hours | Min. (Month, | Day, Year) 1910 | | lace (Stata or Foreign try) .nsylvania |
| Mow M | | 10a. State 10b. County | 10c. C | ity, Town or L | ocation | | | | 1 | 0d. Inside City Limits |
| Mary Services | ctor | Maryland Prince Ge | orges | New Car | rrollto | on | | | 1 X Yes 2 □ No | |
| 23a or 28 | ral Director | 10e. Sfreet end Number 6219 85th. Place | | | 10f. Zip C | 20784 | | 10g. Citizen of V | | try? |
| ar, or hems | by Funeral | 11. Maritel Status 1 Never Married 2 Married 3 Nowed 4 Divorced | 12. Was Decedent Ever in United Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: | | _ | nt of Hispanic Origi y Cuban, Mexicen, No Specify: | n? (Specify Yes or I Puerto Rican, etc.) | No- 14. Rad Ble Specify | e - Americ ck, White, | etc. |
| 72 ho meturn Scal I | Completed | 15. Decedent's Educ (Specify only highast grada | cetion | 16a. Dece | dent's Usual | Occupation | of working | 16b. Kind of B | | |
| S Med | mple | Elementery/Secondery (0-12) | College (1-4or 5+) | lifa. | | dona during most of ratired) | or working | | | |
| har thu | Co | 12 17. Fether's Neme (First, Middle, Last) | 00 | | Homen | | a blama /Final Adida | | Home | |
| hental i ked of ic eve | o Be | Michael Erdesky | | | | Sus: | s Name <i>(First, Midd</i> an Kaza | ila, Maiden Suman | 1a) | |
| mark mark | ř | 19e. Informant's Name/Relationship (Typ | oe. Print) | 19b. Maili | ing Address (| | or Rural Routa Num | nhar City or Town | State Zin | Code) |
| 27 is 27 is | | Rosemarie Connors | (Niece) | | | | d. Silver | | | |
| Itsem of the course | | 20a. Method of Disposition | 20b. | Place of Dispo | osition (Nama | of | Dete | 20c. Location | City or To | wn, State |
| nent o ant: If ary or | | 1XBurlal 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Spacify) | emoval from State | . Oliv | | | 4/8/99 | Washingt | on. | D.C. |
| Separtmer mportant any injury ance. | | 21. Signature of Funeral Service License | 9/ | 2: | 2 Name and | Address of Facility | neral Hom | | | |
| 6620 | | nechant of | rent- | | | | Rd. Lanh | | land : | 20706 |
| hysician | | 23a. Part1. Enter the disease, or complice controls on the control of the control | cations that caused the dea e ceuse on each line. | th. Do not en | ter the mode | of dying, such as co | erdiac or respiratory | arrest, | | Approximate tnterval Between Onset and Death |
| /Medical | | tmmediate Ceuse (Final disease or condition resulting in death) e | Acute | MY | 0000 | interest - | Infere | KON | | 8 hower |
| xaminer | _ | resulting in death) | Due to (| or es a conse | | | | | | 0 /1400.5 |
| lsit. | ulue | _ b. | | | | | | | 1 | |
| physician end s the burial-transit | I Examiner | Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury | Due to (| or as a consec | quence of): | | | | | |
| ing physi | Medical | that initiated events resulting in death) Last | Due to (d | or as a consec | quence of): | | | | | |
| tendir or use | | d. | | | | | | | | |
| the et | slci | Part II. Other algnificant conditions cont | ributing to death buf not res | sulting in the u | inderlying cau | se given In Part I. | 23b. DI | d tobacco usa co | ntribute to | the cause of death? |
| been signed by the ettendi | by Physician/ | Preumania | 12-11-6-70 | wien | | | 10 | Yee 2□ No | 3 Prob | pably 4 Onknown |
| ins fav requires the title deen certificate be ate has been signed by the ettending physicial page 2 should be deteched for use es the burner. | Completed | | | | | | | as an autopsy formed? | ave | ore autopsy findings sileble prior to npletion of ceuse death? |
| | E | | | | | | 10 | Yes 21 No | 1 🗆 | Yas 2□ No |
| ertific ector, | Be | 25. Was cese referred to medical examiner? | | | | 28. Plece o | of Deeth (Chack only | y one) | 1 | |
| this co | ၉ | 1 ☐ Yes 2 ☐ No | | ER/Outpatier | | _ | ing Home 5□ Re | | |) |
| ath. x: After t he funera | atlon: | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | M 280 | i. Injury at Work? 1 ☐ Yes 2 ☐ No | | e how Injury occur | red | |
| within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: | 3 Sulcide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Special | | reet, fectory, o | office | | (Straet and Numb own, Steta) | er or Rura | Routa Number, |
| uithin 24 hours efter death. To the Furneral Director: After this certific completely filled in by the funeral director. | edical | 29a. Certifier (Check only one) 1 Certifying Phyel 2 Medical Examin | clan: To the best of my known: On the basis of examina and manner stated. | owledge, deat ation and/or in | h occurred at vestigation, in | the time, date and my opinion, death | place, and due to the occurred at the time | e ceuse(s) end ma e, date and place, | inner as st and due fo | ated. the cause(s) |
| With com | Σ | 29b. Signature end fitle of certifier | 1/100 | | 290.1 | Icense number | | 29d. Date signe | (Month, L | Jay, Year) |
| 5) | | 30. Neme and address of person who con | | m 23a) (Type, | Print) | IVE PL | AE. 1 | EABROS | 210 | 20704 |
| Stat | | 31. Date filed (Month, Day, Year) APR 0 6 1999 | 32 Registrar's Signa | | 1 | | | | | |

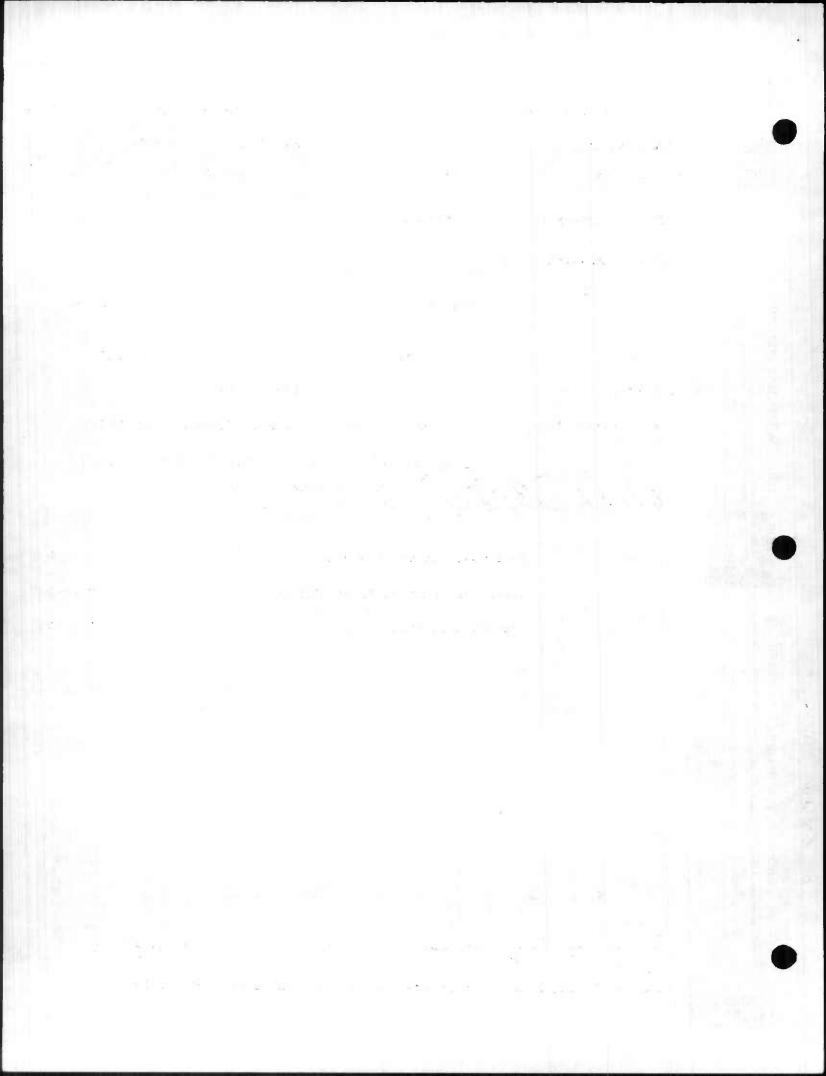
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Division of Vital Records, P.O. Box 68760,

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| | Certificate of D | Death | F | Reg. No. | | | | | | |
|---|---|--------------------------------|---------------------------------|-----------------------------|------------|---|--|--|--|--|
| | . Decedent's Name (First, Middle, Last) | | 2. Date of Dea Month | th Dey | Year | 3. Time of Deat | | | | |
| an | Thomas J. Niland | | April | | | 12:08 a | | | | |
| ical ner | | b. City, Town, or Lo | | | | | | | | |
| | Memorial Hospital | Cumber1a | ınd | A11 | egan | v | | | | |
| П | . Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, De) | | | plece (Stete or For | | | | |
| | 234-38-8116 | Hours Min. | Mar 27, | 1927 | Cour | WV | | | | |
| | Isual Residence of Decedent | | | | | | | | | |
| | 0a. State 10b. County 10c. City, Town or Location | | | | 1 | 10d. Inside City Li | | | | |
| Director | WV Mineral Piedmont | | | | | Yes 2 | | | | |
| ĺ | 0e. Street end Number 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? | | | | |
| | 80 W. Hampshire Street 26750 | | | USA | | | | | | |
| 3 | 1 Marital Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of His | ispanic Origin? (Sp | ecify Yes or No- | 14. Race - American Indian, | | | | | | |
| | Armed Forces? ff Yes, specify Cuben 1 □ Never Married | | Hican, etc.) | | ck, White, | etc. | | | | |
| | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1945-47 1 ☐ Yes 2 ☐ No | Specify: | | Specif | W. W | hite | | | | |
| | 15. Decedent's Education 16e. Decedent's Usual Occupat (Specify only highest grade completed) (Give kind of work done du | ation | | 16b. Kind of B | usiness/In | dustry | | | | |
| ury or other traumatic average of the Table 1 To Be | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done du life. DO NOT use retired) | luring most of work) | ing | | | | | | | |
| | 8 Carman | | | Rai | lroad | | | | | |
| | | 18. Mother's Nam | e (First, Middle, | | | | | | | |
| | Ignatius Niland | Blanche | (Ahern |) | | | | | | |
| Important: If Item: any injury or othe | 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street er | | | | Stete. Zir | Code) | | | | |
| | | | | | | | | | | |
| | Inez Nilandwife 80 W. Hampshire Oa. Method of Disposition 20b. Place of Disposition (Name of | e Street | Date | 20c. Location | | | | | | |
| | WE Burial 2 ☐ Cremetion 3 ☐ Removal from State cemetery, cremetory or other place | | | | | | | | | |
| | 4 Donation 5 Other (Specify) St. Peter's Cemete | | 04/10 | Westernport, MD | | | | | | |
| | 21. Signature of Funeral Struipe License 22. Name and Address Fredlock Fu | | | | | | | | | |
| | Was Ar William Piedmont, T | | | | | | | | | |
| nysician | 23a. Part 1. Enter the disease, or complications that the part is the second point of the mode of dying, shock, or heart failure. List only one cause on each line. | g, such es cardiac | or respiratory ar | rest, | | Approximete Interval Betwee | | | | |
| | anough of real families. Else only one saude on each inte. | | | | 1 | Onset end Dea | | | | |
| | mmediate Ceuse (Final lisease or condition Post Obstructive Pneumonia | | | | | 3 weeks | | | | |
| | resulting in death) a. TOSE OBSERCETIVE THEURIOTER Due to (or as a consequence of): | | | | | | | | | |
| j | | | | | ì | 3 weeks | | | | |
| | b. Malignant Ventricular Arrythmias Due to (or as a consequence of): | | | | | | | | | |
| | any, leading to immediate | | | | | | | | | |
| | Course (Disease or injury hat initiated events | | | | | 3 weeks | | | | |
| | nat initiated events Due to (or es a consequence of): | | | | | | | | | |
| v/Medical | d | | | | | | | | | |
| Cla | | | 1 | | | | | | | |
| Physician | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | | |) DO | Yes 2 No | 3 Pro | obably 4 Un | | | | |
| by | | | | | 0.45 14 | loso autono die d | | | | |
| iec | | | 24e. Wes perfo | en eutopsy med? | av | Vere autopsy find vaitable prior to ompletion of caus | | | | |
| Completed | | | | | of | death? | | | | |
| | | | 101 | Yes 2 No | 1 | □Yes 2□ No | | | | |
| | 5. Was case referred to medical | 26. Place of Deal | th (Check only o | ne) | | | | | | |
| | examiner? 1 Yes No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other | or. | ome 5 Resid | | her (Speci | ity) | | | | |
| | 7. Manper of Deeth 28a. Date of Injury 28b. Time of 28c. Injury | | 28d. Describe | | | | | | | |
| | | Yes 2 □ No | | | | | | | | |
| | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office | | | | ber or Rui | ral Route Number | | | | |
| | 4 Homicide building, etc. (Specify) | | City or Tov | vri, Stete) | | | | | | |
| | 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time | ne, dete and place | and due to the | cause(s) and m | anner as | steted. | | | | |
| 5000 | (Check only one) Check only one) Check only one) Check only one Check one Check only one Check only one Check only one Check one Check one Check one Check one Check one Check one | pinion, deeth occur | red at the time, | date and place, | and due | to the cause(s) | | | | |
| 5 | Do. Signature and title of certifier 29c. License | e number | | 29d. Dete signe | ed (Month | , Dey, Year) | | | | |
| | 1 mil | | | | 0 | | | | | |
| | D 187 | 769 | | April 7 | 2 | 1999 | | | | |
| | O. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | | |
| | Dr. James Raver, Memorial Hospital, Suite 400, | , Cumber! | Land, MD | 21502 | 2 | | | | | |
| 9 | 1. Date filed (Month, Day, Year) 32. Registrer's Signeture | | | | | | | | | |
| | APR 1 2 1999 | | | | | | | | | |
| | | | | | | | | | | |



| Physician As Facility harder (Prod restriction) Queen As Carry (Prod. As | | | | | Certi | ficate of | f Death | F | leg. No. | 1 6/1 / | | | |
|--|-------------------------------|--|-----------------------------|-----------------|-----------------------------------|------------------------------------|--|---|--------------------------------------|--|--|--|--|
| Annor Care Nursing Home 4 Facility Name (for or standard pre- pre- pre- pre- pre- pre- pre- pre- | | 1. Decedent's Name (First, Mide | dle, Last) | | | | | | | 3. Time of | | | |
| ## Sealing Name (For Antenthoris power and named) ## Amon's Care Nursing Home Social Search Name (For Antenhoris Price Georges 10 | • | Nathan | 01be | | | | | 2 42 2 2 44 | | 12:30 | | | |
| School Security Number Galley Topic To | | 4a Facility Name (If not institution | on, give street and number | er) | | | 4b. City, Town, o | | | of Death | | | |
| Second of the process of the proce | | Manor Care Nu | rsing Home | | | | Largo | | Prince | Georges | | | |
| DRSS-20-1766 Section | Funeral | | 6. Sex 7. | | N | | | s. 8. Date of Birtl n. (Month, Day | Year) | 9. Birthplace (State of Country) | | | |
| The Black Prince of State and Number of 100. Clarge of State and Number of State of Number 100. Clarge of State of Number 100. Clarge Director | | 1201 | 97 | Yrs. | | | April | 17 1901 | Poland | | | |
| New York Queens Jackson Heights 10s. Sires and whether 10s. Sires at an Whenber 34-22 87th Street 11street 11s | 1 | | у | 10c. City, | Town or Locat | tion | | | _ | 10d. inside Ci | | | |
| Bellementary/Secondary (0-12) College (1-for 54) Garment Business Self-Employed | of sho | New York Ougo | n c | Inc | kaan U | oichta | | | | 1 X Yes | | | |
| Self-Employed College (1-4or 5+) College (1-4 | 28a- | 10e Street and Number | 113 | Jac | - | | | | IOa Citizen of W | /hat Country? | | | |
| Bellementary/Secondary (0-12) College (1-for 54) Garment Business Self-Employed | \$ B | 3/1=22 87+h S+m | oot | | | | | | | | | | |
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| Bellementary/Secondary (0-12) College (1-for 54) Garment Business Self-Employed | by I | 3 Widowed 4 □ Divorce | 16 Mars (0) | | 1 🗆 | Yes 2 N | o Specity: | | Specify: White | | | | |
| Bellementary/Secondary (0-12) College (1-4or 5+) Garment Business Self-Employed | De partir | 15. Decede | | | 16a. Deceden | it's Usual Occ | upation | | 16b. Kind of Bu | | | | |
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| Pettrolitan Crematory 4/6/99 Alexandria, Virgin 22. Signatus uneral Service Licensee 22. New and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Papt. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximation of the control of the co | Aente rked tic e | Joseph Ohlba | um | | | | Ella | Blucher | | | | | |
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| 23a | E E E | De Callin | 1 1 100 | 1 | | | | | | 1 00=06 | | | |
| Medical adminer Part Common Comm | | 23a Park Enter the disasse | or complications that cause | ed the death | | | | | | | | | |
| Sequentially list conditions, farry, last angle to immadiate cause. Enter Underlying Cause (Disease or Injury Inst Initiated event). Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Part It. Other algnificant conditions contributions contri | Medical | Immediate Cause (Final disease or condition resulting in death) e. CAPDIAC ARRYTHMIAG Due to (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, farry, last quite cause. Enter Underlying Cause (Disease or Injury fast initiated eases. Enter Underlying Cause (Disease or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases. Enter Underlying Cause (Disease or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases. Enter Underlying Cause (Disease or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases. Enter Underlying Cause (Disease or Injury fast initiated eases or Injury fast initiated eases or Injury fast initiated eases. Enter Underlying Cause (Disease or Injury fast injury fast initiated eases or Injury fast initiated eases or Injury fast injury fa | je L | | (ORO | MAN | 4 | 1754 | DISPAS | | | | | | |
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| Deposition of the contribution of the contribu | ysici ne bu | fhaf Initiated events | C | Due to (or a | as a consequer | nce of): | | | | | | | |
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| 24e. Wes en eutopsy available prior completion of of death? 1 Yes 2 No | r use | | d. | | | | | | | | | | |
| 24e. Wes en eutopsy aveilable prior completion of of death? 1 Yes 2 No 1 Yes 2 25. Was cese referred to medical examinar? 1 Yas 2 No 1 Yes 2 26. Place of Death (Check only one) 27. Mennar of Death 1 Nursing Homa 5 Residence 6 Othar (Specify) 28a. Dete of Injury 28b. Time of Injury 1 Yes 2 No 27. Mennar of Death 2 2 2 2 2 2 2 2 2 | ed fo | Part It. Other aignificant condit | lons contributing to death | but not result | ting in the unde | erlying cause | given in Pert i. | 23b. Dld t | obacco use cor | ntribute to the cause | | | |
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| The state of the s | 5.8 | | | | | | | _ | | | | | |
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| 25. Was cese referred to medical examinar? 1 | ta ha | | | | | | | 101 | es 2 No | 1 ☐ Yes 2 ☐ | | | |
| 27. Menner of Death 28a. Dete of Injury 28b. Time of Injury 28c. Time of Injury | tor, p | 25. Was cese referred to medic | 91 | | | | 26. Place of D | eath (Check only o | ne) | | | | |
| 27. Menner of Death A statural | 00 | | Hospital: | atianf 2 E | R/Outpatient | 3 DOA | Other: Nursing | Homa 5 ☐ Resid | lence 6 Oth | ar (Specify) | | | |
| Jaul Glormer you so 031817 84-05-99 | er th | | 28a. Dete of It | njury 2 | | 28c. In | jury at | 28d. Describe h | ow injury occurr | ed | | | |
| Jaul Glomes year no 031817 84-05-99 | r: Aft | - leaves | | Jay 10ai, | inquiy | | | | | | | | |
| (a) faul Slower you so 031817 84-05-99 | ecto by # by # | | minad 200. Flace OI | Injury - At hon | 28f. Location (5 | Street and Numb | er or Rural Route Num | | | | | | |
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| Jaul Glomes you so 031817 84-05-99 | Ne Me | 29b. Signature end title of certific | er / | | | 29c. Lica | nsa number | | 29d. Data signed | (Month, Day, Year) | | | |
| | | b foul 4 | James Ge | 40 | | | 031817 | | 04 | 1-05-99 | | | |
| | | 11 - 40 (// | will you | , ,,,,, | | | | | | | | | |
| Paul THOMAS LYOWS 3001 Hospital Dr. Cheverly, MD 20785 | 1-1 | 30. Name and address of person | who completed dauge o | f death /Item ! | (Tyne Pri | int) | | | | | | | |

The second second

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Last) 2. Date of Death 3. Time of Death Month 1999 April 4 1:10 AM Margaret Lenore Paddy 4b. City, Town, or Location of Daath 4a Facility Name (If not Institution, give street and number) 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 24 Hrs. Hours Min. If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sax 1□ M 2♥ F Months Days 578-07-8726 84 Yrs. Jan. 21,1915 Wash., D.C. Usual Rasidenca of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 462 Colonial Ridge Lane 21012 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Education 18. Mother's Name (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Anna Mae Thomas George Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James William Paddy / son Arnold, Md. 462 Colonial Ridge Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Data 20c. Location - City or Town, State 1 XBuriai 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-7-99 Lincoln Cemetery Brentwood, Maryland 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Sarvica Lican 147 Duke of Gloucester St. Annapolis, Md. 21401 Q Har 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia. disease or condition resulting in death) Due to (or as a consequenca of) Due to (or as a consequenca of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown ery disease. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes al No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify)

Physician /Medical Examiner

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the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Hospital or Attending Physician:

Physician

* /Medical

Examiner

10e State

Funeral

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Completed

7 is marked other than "naturel", or items 23a or 28a-f shot treumstic event, the Medical Example Final be notified at

permit. Peges 1 end 2 should be filed within 72 hours effer c Department of Health end Mental Hygiene. Introcrant: If Item 27 is merked other than "naturel", or item any injury or other treumatic event

Maryland 21215-0020

Baltimore,

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deeth

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medical ρ Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| examiner? | |
|---------------------|-----------|
| 27. Mapner of Death | 5 Pending |

5 Pending investigation 6 Could not be detarmined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Tima of

28a. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

29a. Certifie (Check only one)

2 Accidant

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

31. Date filed (Month, Day, Year)

29c. Licensa number

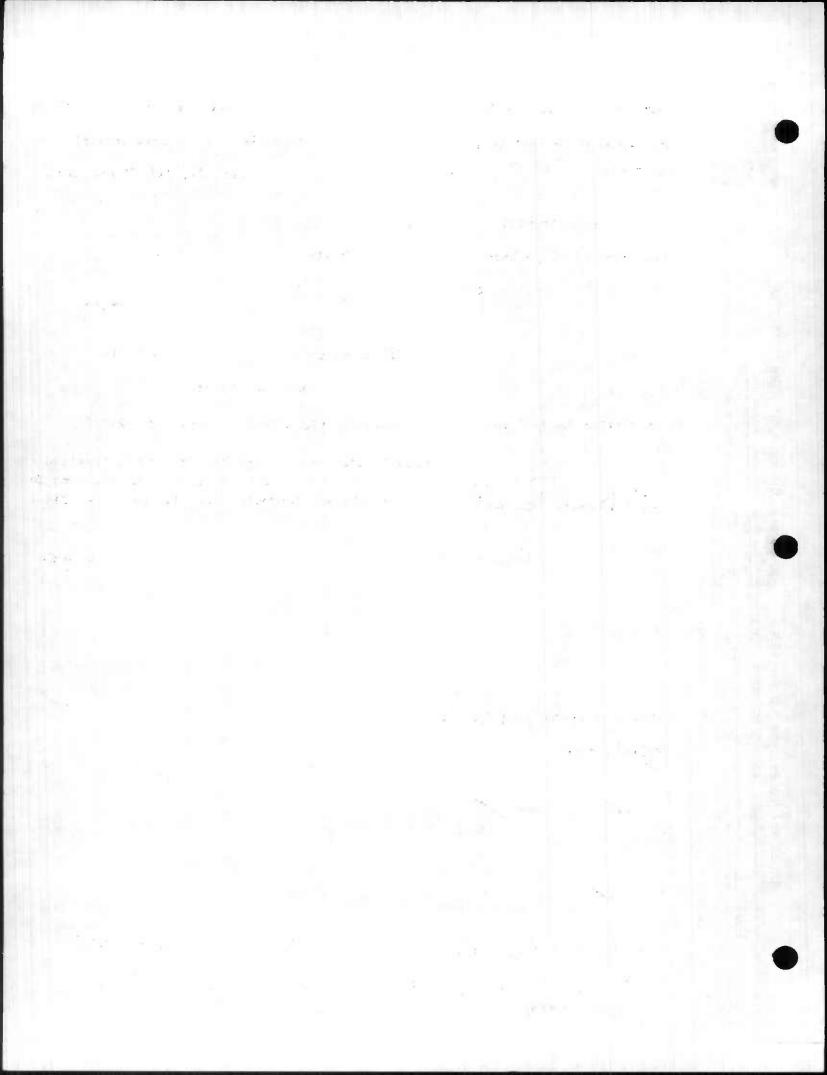
29d. Data signed (Month, Day, Year)

ath (Item 23a) (Type, Print)

APR 0 6 1999

32. Registrer's Signature

State Registrar

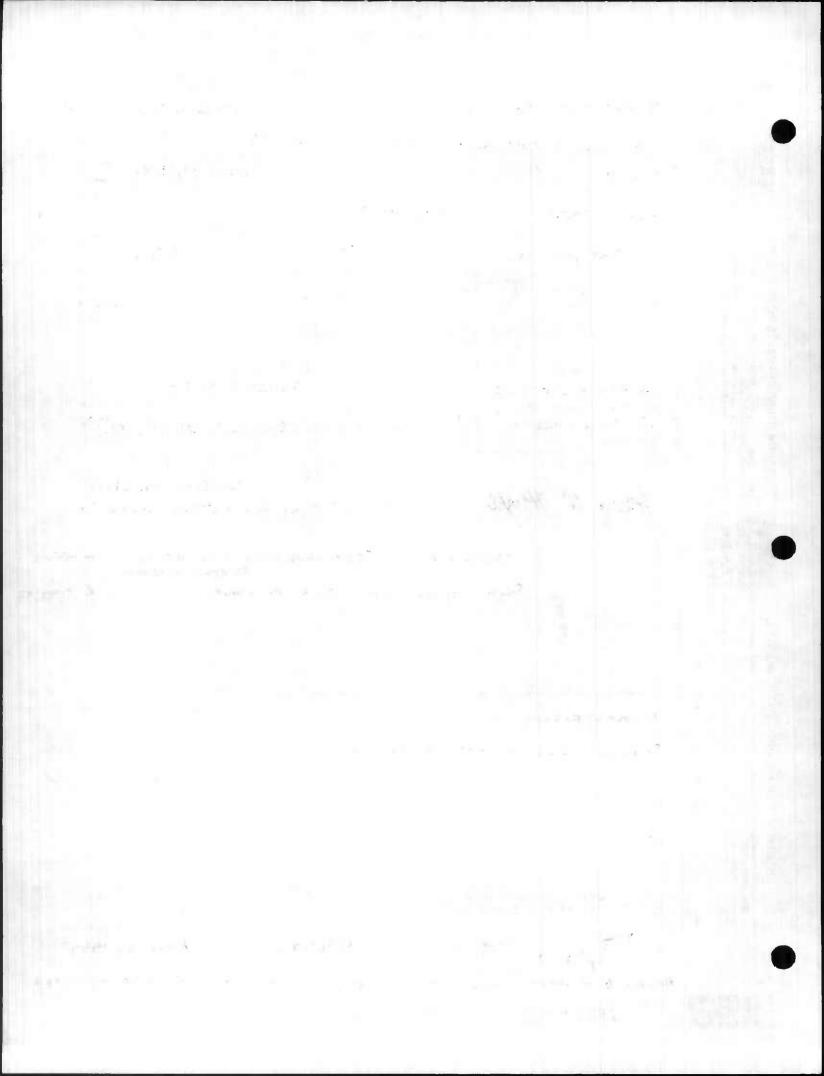


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Artimus Scott Pattison April 3, 10:55 PM 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Ellicott City Howard St. Agnes Rehabilitation Center Months Days Houra Min. April 12, 1933 6. Sex 1 M 2 □ F Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs 65 216 30 8050 Director Md Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Md. Howard Marriottsville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. In the firem 27 is marked other than "natural", or items 23a or items 23a or items 23a or items 25a or items 25a. 21104 2560 Thompson Drive U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1953— 1 2 Yes, 2 □ No If Yes, Give 1960 14. Race - American Indien. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 200 Married altimore, Maryland 21215-0020 1 Yes 20€No Specify: White à 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Artimus Zepp Pattison Dorothy P. Martin 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte J. Pattison (wife) 2560 Thompson Drive Marriottsville, Ma. 1104
of Disposition (Name of Date Date 20c. Location - City or Town, Service per cremetory of other place) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/7/99 Marriottsville, MD Crestlawn Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sykesville, Md. 21784 23a. Pahl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest, shock, or heart allure. List only one cades on each line. Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) METASTATIC SOUMOUS COLL CARCINOMA Examiner TO GINE + BRAIN Due to (or as a consequence of): Examiner Squamorscell CARCINOMA OF LUNG months physician and s the burial-transit the death certificata be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or es e consequenca of): Box 68760, Physician/Medical Due to (or as a consequence of): 65 esn signed by the a 23b. Did tobacco usa contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 1 No 3 Probably 4 Unknown MALNUTRITUM by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy ELECTROLYTO IMPARAMICE completion of cause of death? certificate has b irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Waa case referred to medical exeminer?
1 No 2 No director, Be 26. Place of Death (Check only one) Hospitel: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending after death. 1 Yes 2 No Investigation 2 Accident To the Hospital or Attar within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, atreet, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 036974 APRIL 5, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) O. NYANTON MO. 10724 LLTTLE PATULENT PARKWAY , Councia mo 21574 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 7 1999 Registrar

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

| | | | Ce | rtificat | e of | Death | | R | g. No. | 3 4 | |
|---|--|--|---|---------------|----------------------|---------------------------|-------------|----------------------------------|--|------------|--|
| | 1. Decedant's Nama (First, Middla, I | ast) | SA TE | | | | İ | 2. Data of Deat Month | | | 3. Time of Death |
| Physician | William I | | | | | | 4, 1999 | Yaar) | 4:15 PM | | |
| /Medical | 4a Facility Nama (If not institution, g | | ante | | | 4b. City, To | own, or Lo | cation of Death | 4c. County | | 1113 |
| Examiner | | | | | | | | | | | |
| | Doctors Communit | | a last highday | If Under | 1 Vear | Lanl If Under | | D. Date of Bidh | | | orges |
| Funeral | | 10XM 2015 | Months Days Hours | | | | | 8. Data of Birth (Month, Day, | Year) | | olaca (Stata or Foreign htry) |
| Director | 087-14-5672 | 76 |) ''' | | | | | March 1 | 1 1923 | New | York |
| Pu a | Usuai Rasidance of Decedant 10a. Stata 10b. County | 16 | Dc. City, Town or L | ocation | | | | | | 1 | Od. Insida City Limits |
| Manyle H sho | Maryland Prince (| | New Carr | | n | | | ¥XYes | | | |
| vith the Mar or 2844 s be notified | 10e. Street and Number | 001800 | | 10f. Zip | | | | 1 | 0g. Citizen of V | What Cour | ntry? |
| 23a or | 6119 85th. Place | 2 | | | 20 | 0784 | | | Α. | | |
| ofter death viter tems 23s other must | 11. Marital Status | 12. Was Decedant Eva Apped Forcas? | r in U,S. 13. | Was Deced | dant of H | lispanic Or an, Maxica | lgin? (Spe | city Yas or No- Rican, atc.) | | e - Amario | an fndian, atc. |
| Dy hi., | 1 Navar Marriad XX Married 3 Widowed 4 Divorced | 1X Yas 2 □ No if Yas, Giva Yaar or Datas: | | 1□ Yas | | Specify: | | | | Whi | |
| 1 21215-0 ed within 72 ho ygiene. rer than "neture rt, the Medical Completed | 15. Decedant's | | 16a. Dece | dent's Usua | al Occup | pation | | | 16b. Kind of Bu | ısinass/In | dustry |
| 215 lin 7 | (Specify only highast g | | (Give | DO NOT us | rk dona sa retire | during mos d) | st of worki | ng | | | |
| vithin within than the Me | Elementery/Secondary (0-12) | Collaga (1-4or 5+) | X-R | Ray Te | chni | ician | | | N.I. | Н. | |
| | 17. Fathar's Nama (First, Middla, Lat | | | , | | - | ar's Nama | (First, Middle, A | | | |
| laryland 2 2 should be filed end Mental Hygi is marked other aumatic event, To Be Co | | , | | | | | | | | / | |
| should and Men marke | Wilford Plante Rose Lacombe 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or | | | | | | | | | | |
| Maryland 2 should be file d 2 should be file the end Mental Hy 7 is marked othe traumatic event To Be (| | | | | | | | | | | |
| - 5 = 6 = | Cecilia S. Plan | | | | | Place | New | Carroll | | | |
| or Heal | 20a. Mathod of Disposition | | Place of Disp cematary, cra | osition (Nen | ne of thar plac | ce) | 1 | Data | 20c. Location - | City or To | own, Stata |
| timo Pege ment c tant: if jury or | 1 ABurial 2 Cramation 3 4 Donation 5 Other (Spec | | Fort Lin | coln | Ceme | eterv | 4 | /9/99 B | rentwoo | d. M | D |
| Baltimore, pamit. Peges 1 s Department of He important: if Nem any Injury or othe pnes. | 21. Signature of Junaral Sarvice Lic | 2 | | | | | | | | | |
| B Page Page Page Page Page Page Page Page | be delle | de 1 | | Rendo | n/Ha | ale Fu | únera | 1 Home | | | |
| / | 1 perano | Jenu- | | 9013 | Anna | apolis | s Rd. | Lanham | , Maryl | and | |
| | 23a. Pay Enter the disease, or co | polications that caused the yorle causa on each line. | daath. Do not an | itar tha mod | a of dyir | ng, such es | cerdiac d | or respiretory erro | est, | - 1 | Approximate Interval Between |
| Physician | / | | , | | | | | | | 1 | Onsat and Death |
| /Medical | Immediata Causa (Final disaasa or condition | (FOFARA | 1 100 | MADR | 041 | ACE | • | | | | 1 DAY |
| Examiner | issaes or condition esulting in deeth) a EREBRAL HEMORRHAGE Dua to (or as a consequence of): | | | | | | | | | | 1 111 |
| 9 | | CEREBRO | MASCUL | 00 | T | ISEI | ACT | | | 1 | ONE |
| x 68760, ertificate be executed ling physician end ees the bunial-transit | Sequentially lief conditions | THE BRUI | a to (or as a conse | 41 | V | 1761 | 106 | | | | YEAR |
| Exa | Sequantially list conditions, if any, leading to immediata ceusa. Entar Undarlying Cause (Diseasa or injury that initiated avants | 46 | In Da | | 6 | - 1.0 | Pa | rdiova | C N A | 0 | THEAMS |
| 68760, ificate be expression as the burial edical E | Cause (Diseasa or injury | HYPERTENSI | UG 14KTE | RIDSE | LEK | DIK | LA | HVUILL | SCULA | K | 1900,0 |
| x 6876 entificate be ling physicia se es the bu | rasulting in death) Last | Due | to (or as a consa | quance or): | | | | | DISET | 156 | / |
| X 6 Sentific sentific sentific | | d | | | | | | | | | |
| P.O. Boy at the death or the by the attend eteched for us Physician | | | | | | | | | | 1 | |
| . 0 0 0 | Part II. Other significant conditions | contributing to death but n | ot rasulting in tha | undarlying c | eusa giv | an in Part | 1. | 23b. Dld to | bacco use co | ntribute t | o the cause of death? |
| P.O. that the ed by the deteche | | | | | | | | 1 🗆 Y | 2 10 | 3 Pro | bably 4 Unknown |
| S s s y | | | | | | | | | | | |
| | | | | | | | | 24e. Was a | n autopsy | 24b. W | ara autopsy findings silabla prior to |
| w raqu s been shoul | | | | | | | | perion | now! | CO | mplation of ceuse death? |
| The taw requires take hes been s page 2 should Completed | | | | | | | | | .4.1 | | |
| = F # a 0 | / | | | | | | | 1 🗆 Ya | s 2LLM6 | 11 | ☐ Yas 2☐ No |
| of Vital Physician: The physician: The conflicate ral director, page Cc. | 25. Was cese rafarrad to medice i axaminar? | 11 | - | | 101 | | e of Daath | (Check only on | e) | | |
| Physic rail dire | 1 Yas 2 TNo | Hospital: 1 Inpatiant | 2 R/Outpetie | | | 4 L N | ursing Ho | ma 5 🗆 Rasida | nce 6 Oth | ar (Specil | (y) |
| ding Ph h. After th funeral | 27. Manner of Death 1 Death 5 Panding | 28a. Data of Injury (Month, Day Ya | 28b. Tima o | of 2 | 8c. Injur Wor | ry at rk? | 1 | 28d. Dascribe ho | w injury occur | red | |
| ion atio | 2 Accident investigati | | , inquiy | М | | Yas 2 | No | | | | |
| Oivision or Attending effer death. Director: Affei lin by the fune ertification | 3 Sulcida 6 Could not determine | 28e. Place of injury | - At homa, farm, st | reat, factory | , office | | 1 | 28f. Location (St | Street and Number or Rural Routa Number, | | |
| Division of the or Attending P as effer death. al Director: After the or in by the funers Certification: | 4 Homicida | building, atc. (5 | Spacity) | | | | | City or Towr | , State) | | |
| Hospital 24 hours 24 hours Funeral I letely filled | 29a, Certifier 1 Certifying F | hysician: To the best of m | v knowledge deel | th occurred | at the fir | me date er | nd place s | and due to the co | use(s) and ma | nner es s | tetad |
| he Hospi in 24 hou he Funer pletely fill edical | (Check only 2 Medical Ext | miner: On the basis of axi | amination and/or in | vastigation, | in my o | pinion, das | ath occurr | ed at tha tima, de | eta and place, | and due to | o the cause(s) |
| 4 5 5 5 | 29b. Signayud Da yu Ar pertition I | and manner stated | | 200 | Llongs | sa number | | | 9d. Date signe | d (Month | Day Yearl |
| 0 2 0 0 | 2110110 | LILLING | F | 290 | Licaris | a number | 100 | 1 | Ju. Date Signe | e G | G |
| - >- 0 | MI I I 1/1/1 4011 21 | -1 /2 // 8 // // // | / / | | | | MA . | / | A I | - Y | |
| (2) | MUMULT | JULIUV VI | / | 4 | 1.1 | 600 | 51 1 | | 4-6 | 0 / | 1 |
| (5) | 30. Nama and addrass of person wh | completed ceuse of death | (Nem 23a) (Type | Print) A | / · / | 60 | 5// | | MA | QU) | ANID |
| <i>(5)</i> | 30. Nama and addrass of person wh | completed ceuse of death | T(Tem 23a) (Type | Print) A | b, 1 | 66 | or D | PLLIMA |) MA | 242 | AND |
| (5) State | 30. Nama and addrass of person when the second state of the second | SON MD 5 | 70185 | Plu Au | b. / | lew (| PARR | OLLTON |) MAI | 242 | AND 184 |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1999 12:40p.m. April 3, Thada G. Payne /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 5/31/11 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months 1□ M 2Q F Yrs. DENVER, COLO. 577-24-0535 87 Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any fujury or other treumstic avent, the Medical Engineer must be notified at once. Yes 2 No Director MONT SILVER SPRING 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1220 EAST WEST HIGHWAY 20910 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 YEARS College (1-4or 5+) YEARS PERSONNEL OFFICE WORKER DC GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) HORBART GREEN SADIE (UNK) 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) FRANK V. PAYNE (HUSBAND) SAME AS 10A, B, C, E, D, &F 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2000 remation 3 ☐ Removei from State METROPOLITAN CREMATORY 4/8/99 ALEXANDRIA, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 6 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility John T. Rhines Company Wash., D.C. 20017 3030 12th St., N.E. 1 lammery 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical ASPIRATION PNEUMONIA Examiner Due to (or es a consequence of): Examiner ACHALASIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): SUBEUDOCARDIAL MYOCARDIAL INFARCTION Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ILEUS Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed MALNUTRITION 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes XXNo 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner steted. (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D41341 4/3/99 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) JEROME, MD KAREN L. 8700 GEORGIA AVENUR, SUITE#400, SILVER SPRING, MD.

State Registrar 31. Date filed (Month, Day, Year) APR 0 6 1999

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P.O. Box 68760.

Division of Vital

Physician:

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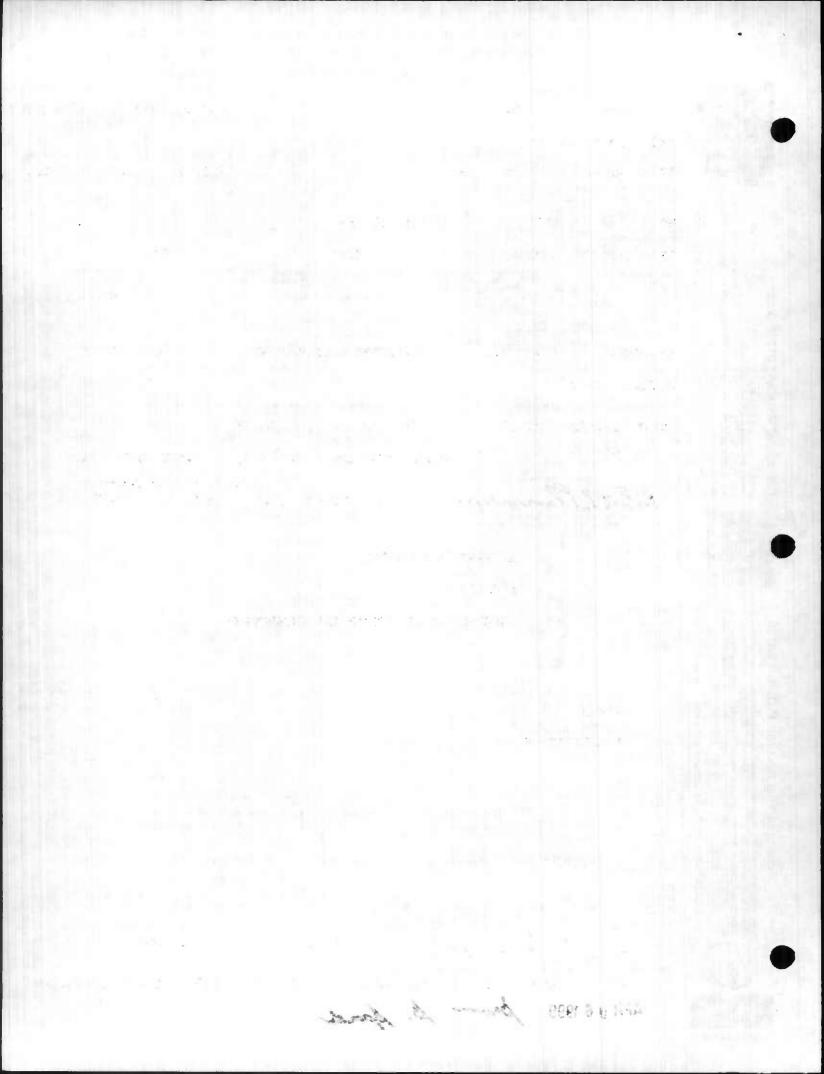
To the Hospital c

Registrar's Signeture

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with the Merylend

3altimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death PORTER B.

| Physician |
|-----------|
| /Medical |
| Examiner |

Funeral Director

Pages 1 end 2 should be filled within 72 hours after death with the Meryland nent of Health and Mental Hygiena and of Health and Mental Hygiena and: If item 27 is marked other than "naturel", or items 23s or 28s-f show any or other traumatic event, the Medical Examinet must be notified as permit. Page Department of Important: If eny Injury or once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760 signed by the a been si s certificate has b Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice Aftar this certification afuneral director, I To the Hospital or Attendir within 24 hours eftar daath. To the Funeral Director: Al completaly filled in by the fu

g

Completed

Be

Certification: To

29a. Certifier

Medical

State Registrar

1. Decedant's Nama (First, Middla, Last) 3. Tima of Death MARCH 31,41999 Yaa 6:15pm MARGARET 4c. County of Death
PRINCE GEORGES 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, giva street and number) PRINCE GEORGES HOSPITAL CHEVERLY If Undar 24 Hrs. 5. Social Security Number If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaer) Months Days Hours 1□ M 2□ F 84 216-18-3817 Yrs. 5,1915 Virginia Usuai Rasidance of Decedant 10d. Inside City Limits 10a. Stata 10b. County 10c. City. Town or Location Md. XXYas 2 □ No Springdale Prince Geroges Director 10f. Zip Code 20774 10e. Street and Number 10g. Citizen of What Country? 3614 Tyrol Drive U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ ∑XNo If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married
3 Widowad 4 Divorced 1 Yas 2 XNo Specify: Specify: Black à Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Coltega (1-4or 5+) 9th Private Dietary Technician 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Virginia Mirth William L Thompson 19b. Meiling Address (Streat end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. informant's Name/Raletionship (Type, Print) Sylvia G. Sharpe/Daughter 3614 Tyrol Drive, Springdale, Md. 20774 20b. Ptace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 🗷 Ramoval from Stata Carver Memorial Cem. 4/6/99 Suffolk, Va. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility J.B. Jenkins Funeral Home 21. Signatura of Funaral Sarvice Licensaa 7474 Landover Rd, Landover Md. 20785 23a. Part1. Entar tha disaasa, or complications that ceusad tha death. Do not antar tha mode of dying, such es cerdlec or respiretory errest, shock, or heart failure. List drily one cause on each line. Approximate Interval Between Onsat and Death immediata Causa (Final disaasa or condition resulting in deeth) Zyeas Due to (or as e consequence of) Examiner Kil Aver Sequentially tist conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Physician/Medicai Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death?

Part ii. Other significant conditions contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

24a. Was an autopsy 25. Was cese rafarred to medicei axaminar? 26. Placa of Daath (Chack only ona)

Hospitat: 1 Yes 2 No 1 inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicida 6 Could not be 4 Homicide

28a. Data of Injury (Month, Day Year) 28b. Tima of

28a. Place of injury - At home, farm, streat, factory, office building, atc. (Spacify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

 Location (Straet end Number or Rurel Routa Number, City or Town, Steta) 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the causa(s) and mannar stated.

1 Yas 2 No

29b. Signature and titla of certifian IND

D15126

29c. Licansa number

29d. Data signed (Month, Day, Year)

1 Yes 2 No 3 Probably 4 donknown

24b. Wara autopsy findings available prior to

complation of ceusa of death?

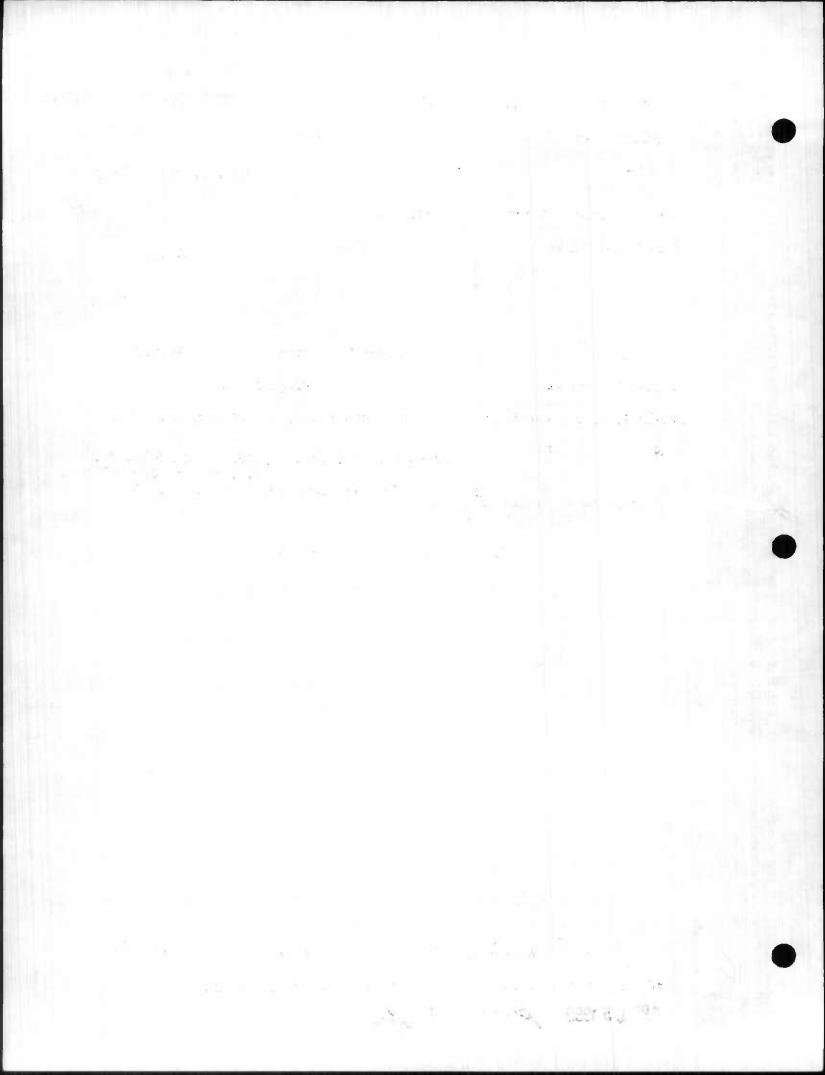
1 ☐ Yas 2 ☐ No

30. Name and addrass of person who complated ceusa of death (itam 23a) (Type, Print)

Joseph Quash, M.D., 9470 Annapolis Road, Lanham, Maryland 20706 31. Deta filed (Month, Dey, Year)

APR 0 5 1999

32. Ragistrar's Signatura



Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or farms 23s any higher or other traumatic event, the Medical Examiner must optice.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

With Europea Director: After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 2 should be deteched for use as the burlansit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

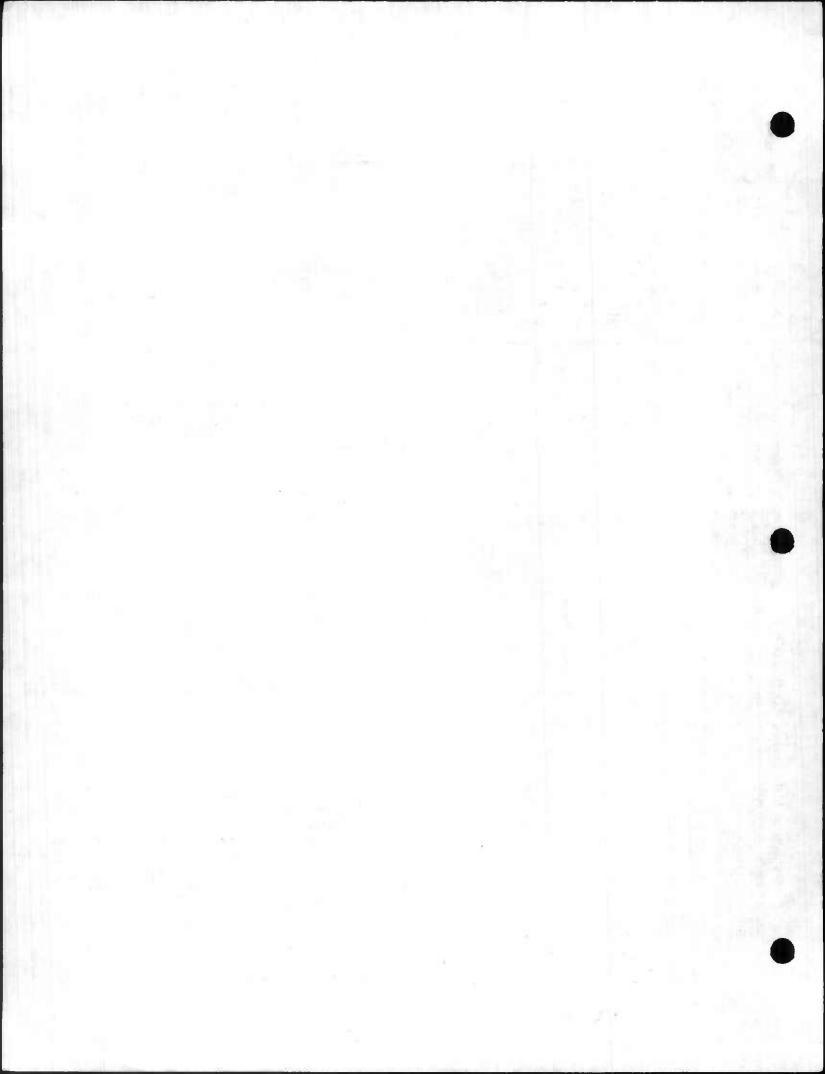
with the Maryland

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | C | Certificate of | of Death | h | F | Reg. No. | 5 1 | 2100 | | | |
|---|---|-----------------------------|---|--|----------------------------------|---------------|--|---------------------------|--------------------------------|---|--|--|--|
| Diama Lym rierce | | | | | | | | Year | 3. Tima of Death | | | | |
| 4a Facility Nama (If not institution, | give street and numb | per) | | | 4b. City, | | April ation of Deeth | 04 199 4c. County | | 12:43 A.I | | | |
| Cumberland Mem | orial Hos | pital | | | Cumi | berlan | d | All | egany | | | | |
| | | Age (In yrs. 27 | last birtho | MODITUS I LA | | Min. | B. Data of Birth (Month, Day ebruar | h v, Year) | 9. Birthpl | Birthplace (State or Foreign Country) | | | |
| Usual Residence of Decedent | | 1 | | | | | | | | | | | |
| 10a. Stata 10b. County | -t | | | r Location | | | | | 10 | Od. tnsida City Limits | | | |
| MD Washing | gcon | Maug | gansv | /IIIe | | 1 | | | | 1 Yas 2 XNo | | | |
| 10e. Street and Number 14040 Village N | Mill Drive | 2 | | 10f. Zip Cod 21767 | le | | | 10g. Citizen of V USA | What Coun | try? | | | |
| 11. Marital Status | 12. Was Decede | ent Ever in U | ,S. | 13. Was Decedent | of Hispanic C | Origin? (Spec | ify Yas or No- | 14. Rac | e - Amarica | | | | |
| 1 Never Married 2 Married 1 Yes, Sive Year or Dates: | | | 1 ☐ Yes 2 ☑ No Specify: | | | | can, atc.) Black, White, atc. Specify: White | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) | | | 16a. D | Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | 16b. Kind of B | 16b. Kind of Business/Industry | | | | |
| Elementary/Secondary (0-12) College (1-4or 5+) | | | | le. DO NOT use re L'YESS | | Restaurant | | | | | | | |
| 17. Father's Nama (First, Middle, La | net) | | *************************************** | | 10 Mot | har's Name | Eiret Middle | Maiden Suman | | | | | |
| Roger Lee Pierce | • | | | | | | Morlen | | 10) | | | | |
| 19a. Informant's Name/Relationship | | | | Mailing Address (Str | | | | | | Code) | | | |
| Patricia Garlitz | z Mothe | | | 004 Sloan | | e Fros | - | | | | | | |
| 4 Minusel Connection of Minuselland Connection Con | | | | f Disposition (Name of ny, crematory or other place) Cemetery Date April { | | | | 8 Lonaconing, MD | | | | | |
| 21. Signature of Funaral Service Lic | censee | | | 22. Name and Ad Eichhorn- | dress of Fac McKen | zie Fu | meral | Home P. | Α. | 127.01 | | | |
| Jarol. 11 | where | Page 17 | | Lonaconii | ng, MD | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events | b | Due to (o | or as a cor | nsequence of): | | | | | 1 | | | | |
| rasulting in death) Last | d | Due to (or | er as a con | nsequence of): | | | | | | | | | |
| Part II. Other significant conditions | | h but not resi | ulting in th | ne underlying cause | given in Par | rt I. | 23b. Did t | obacco use co | ntributa to | the cause of death | | | |
| | | | | | | | 10 | Yaa 2000 | 3 Prot | bably 4 Unknow | | | |
| | | | | | | | | an eutopsy med? | ava cor | are autopsy findings allable prior to mpletion of cause death? | | | |
| | | | | | | | 1/2/4 | 4es 2□No |)E | ∃Yas 2□ No | | | |
| 25. Was casa refarred to medical | | | | | 26. Pla | ce of Deeth | (Check only o | ne) | - | | | | |
| axaminer? 1 X Yas 2 ☐ No | Hospitat: | atient 2 🖒 | KER/Outp | atient 3 DOA | Other: 4 | Nursing Hom | a 5 Rasio | dence 6 Oth | ar (Specif) | 1) | | | |
| 27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident invastigat | | Day Year) | 28b. Tim Inju 2344 | 0.4 | njury at Work? 1 ☐ Yes 2 [| | | now injury occur | njuri | es | | | |
| 3 Suicide 6 Could not detarmine | 268. Place of | Injury - At ho | ome, term | street, factory, offi | ice | | City or Ton | Street and Number, State) | per or Rura | Poute Number, | | | |
| | Physician: To the be aminer: On the basi and manner | est of my knows of axaminat | wledge, d | | | | nd dua to the | cause(s) end mi | | | | | |
| 29b. Signatura and titla of certifiar | | | | 29c. Lic | ense numbe | и | | 29d. Data signe | d (Month, | Day, Year) | | | |
| Dermi Jalus | | | | | | | | April | il 05, 1999 | | | | |
| 30. Nama and addrass of person with | completed cause | _ | | | 01 | | | | | | | | |
| Jennis, | J-Chut | 5 WD | | III Pelli | Stree | t, Bal | timore | , Maryl | and 2 | 1201 | | | |

DHMH 16 Rav 6/95



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| al er | | | L WAY | | ULGG street end nu | m <i>ber</i>) | | | 4 | lb. City, To | wn, or Lo | APR | | 4c. County | | 1. | JAM |
| | | | | | L CENT | | | | | BETHE | | MONTGOMERY | | | | | |
| | - | Security Nu | | 6. Sex | | | rs. last birthday |) If Under Months | r 1 Year | If Under Hours | | 8. Date of | f Birth | | 9. Birthol | ace (Ste | te or Foreig |
| 1 | 261- | 40-88 | 51 | 17 | M 2□ F | 68 | Yrs. | MOITHIS | Doys | Hours | Willi. | Jan. | 17, | 1931 | Flor | ida | |
| ş- | Usuel Re | sidence of | Decedent 10b. Count | lv . | | 10c | City, Town or L | ocation | | | | | | | 10 | d Inside | City Limits |
| l | FL | | | , | | 1 | rawford | | | | | | | | | | es 2 No |
| ŀ | | et and Num | ber | | | | awioid | 10f. Zip | o Code | | | | 10g | . Citizen of V | Whet Count | ry? | |
| l | 13 | Green | lea C | ircl | e | | | 3: | 2327 | | | | | USA | | | |
| - | | ai Status | | | 12. Wes Dec | edent Ever in | U,S. 13. | Wes Dece | | | | | | | e - America | | |
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| - | 3 🗆 🗸 | | 4 Divorce | | Year or E | Detes: | 16a Dece | edent's Usu | al Occup | etion | | | 16 | b. Kind of Bu | isiness/Ind | uetry | |
| | F1 | (Specil | fy only high | est grede | completed) | | (Give | e kind of wo | ork done | during mos | t of work | ing | 10 | b. King of be | 2311103031110 | uony | |
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| | | | me/Reletion | | | | | | | | | | | City or Town, | | | |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month 1999 HELEN MAE MILLER RUMSTAY 03 5:00 PM 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, give street and number) 4c. County of Death ANNE ARUNDEL CROFTON CONVALESCENT CENTER CROFTON if Under 1 Year If Undar 24 Hrs 8. Data of Birth (Month, Day, Year) 03/10/1904 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplace (Stata or Foraign Country) Months Days Hours Min 1□ M 2 F Yrs 95 267 40 1712 Pennsylvania Usual Rasidance of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnslde City Limits 1 Yas XXNo Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2131 Davidsonville Road 21114 USA 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Detes: 14. Race - Amarican Indian. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Bleck, White, atc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yas 2 X No White Specify: Specify: 3 XWidowed 4 ☐ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Spacify only highast grada completed) Etamantary/Secondary (0-12) Collega (1-4or 5+) 8 Salesperson Retail Sales 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fether's Name (First, Middla, Last) George L. Miller Clara Grant 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2705 Fawn Lane, Bowie MD 20715 Christine Miller (niece) 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta 1 ☐ Buriel 2X Cremetion 3 ☐ Ramoval from Stata Metropolitan Crematory 4/5/99 Alexandria VA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licansas 22. Nama and Addrass of Facility Advent Funeral & Cremation Services Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused to death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Intarval Batween Onset end Death Immediate Causa (Final disaasa or condition rasulting in daath) END STAGE ALZHIEMERS DISEASE ONE YEAR Dua to (or as a consaquanca of) ONE YEAR CARDIAC ARRHYTHMIA Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings avellabla prior to 24a. Was an autopsy complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 end 2
Department of Health at
Important: if Item 27 is
any Injury or other trau

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death

Baltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records,

requires that the death certificate be

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Funeral

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Examiner Physician/Medical funeral

by Completed Be

Certification: To

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25. Was casa rafarred to medical axeminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accidant

29a. Cartifier

3 Suicida 4 - Homicida

6 Could not be datarmined

28a. Data of Injury (Month, Day Year) 5 Panding Invastigation

28b. Tima of

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yas 2 No Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28c. Injury at Work?

D34525

Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

April 5, 1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Type, Print)

4000 Mitchellville Road, #220, Bowie MD 20716 SJ RAO, MD

State Registrar 31. Dete filed (Month, Day, Yaar)

29b. Signatura and titla of certifian

APR 0 6 1999



24 hours a Hospital

To the Hospi within 24 hou To the Fune completely fil

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) April Dey Peter Rengel 330 Am 2 1999 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) 3301 Roscommon Drive Glenela Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, NOV 26 Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Months Days Hours Min 1 XM 2 □ F 138-40-8947 46 Yrs. Switzerland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits Howard Glenela 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3301 Roscommon Drive 21737 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) RJ Chemical Sales Inc. sales representative 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Fritz Rengel Rose Marie Pfaffhauser 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Laureen Anne Rengel (spouse) 3301 Roscommon Dr., Glenelg, MD 21737 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Carroll Cremation 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 4-9-99 Hampstead, MD 22. Neme end Address of Fecility 21. Signature of Funeral Servica Licenses Haight Funeral Home & Chapel reano P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that Aused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) mUFCFORMI BY OSLASTOMA Due to (or es e consequença of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certities

death cartificate be axec or Attending Physician:

Physician

/Medical

Examiner

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Funeral

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Completed

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Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar to Department of Haalth and Mantal Hygiena. Important: if frem 27 is marked other than "naturel", or he important: if from 27 is marked other than "naturel", or he pagas y lojury or other traumatic event, the Medical Examines page.

Physician /Medical

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Certification:

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altimore, Maryland 21215-0020

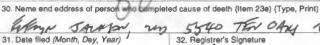
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physician and tha burial-transit Box 68760. 88 usa for P.O. | signed by the a d be detached f Division of Vital Records, page 2 has cartificata director. this funaral Aftar aftar daath. Director: Aft filled in by 24 hours a Hospital completaly within 2 To the

> State Registrar

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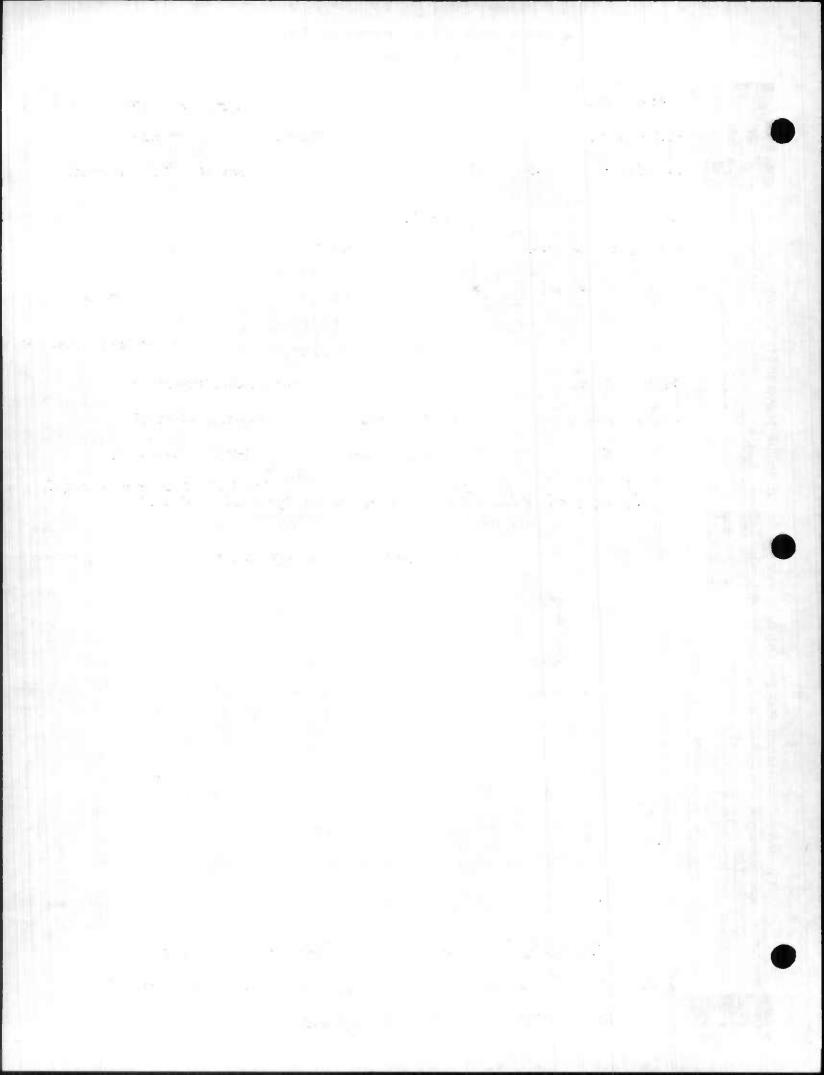


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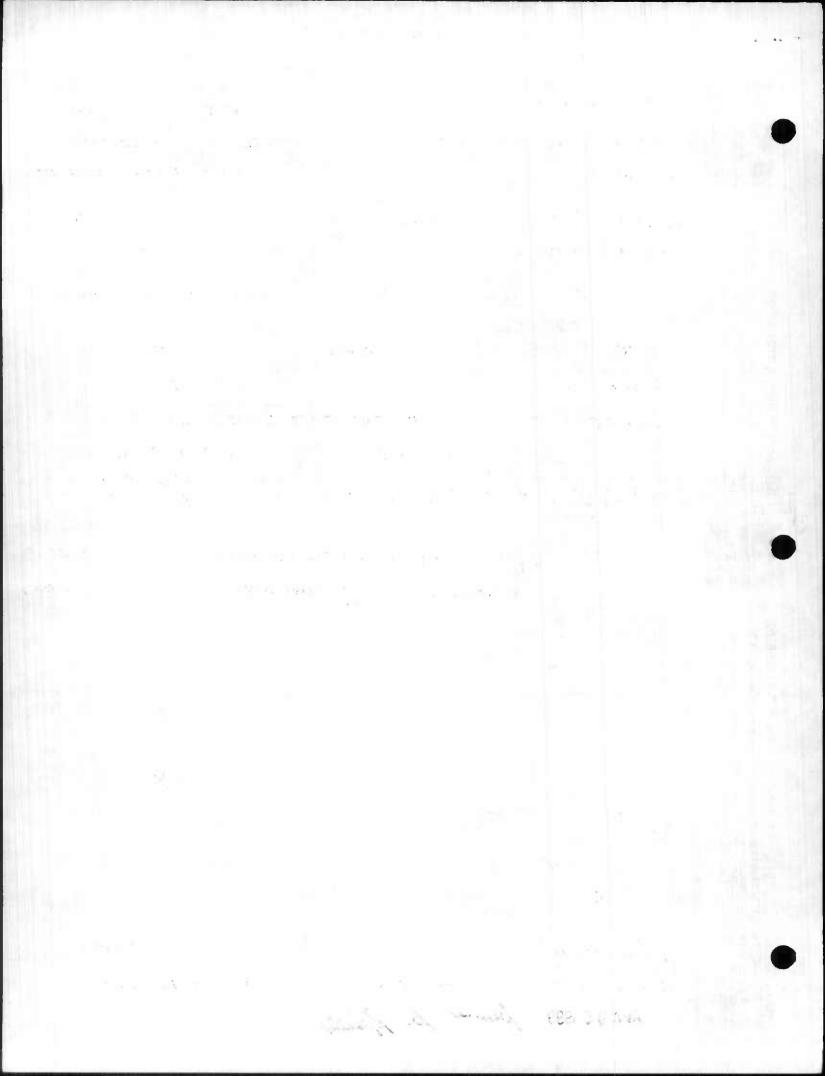
29d. Date signed (Month, Dey, Year)

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29c. License number



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|--|--|--|----------------------------------|---|------------------------------|------------|--|-----------------------------------|----------------------------|--|
| Dhusisia | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of Deat Month | h Day | Year | 3. Time of Death |
| Physiciai /Medica | EDGAR JOSE RUIZ | | | | | | APRIL | | 999 | 10:35 PM |
| Examine | 4a Facility Name (If not institution, give street and nur | | | | 4b. City, To | wn, or Loc | aflon of Death 4c. County of Death | | | |
| 2 | NATIONAL INSTITUTES OF | | | KIII | And the second second | ESDA | | | GOME | |
| Funeral Director | 5. Social Security Number 6. Sex XXM 2 F | 7. Age (In yrs. In 20 | ast birthday) Yrs. | If Under 1 Year Months Deys | | Min. | 8. Date of Birth (Month, Day, August | Year) | 9. Birthpl Count Pu | ace (State or Foreigr ry) erto Rico |
| pus * | Usual Residence of Decadent 10e. State 10b. County | 10c. City | , Town or Los | cation | | | | | 10 | Od. Inside City Limits |
| Aarylan Fahow | 7777777 | | derick | | | | | | | tv Yes 2□No |
| 288 Dorth | 10e. Street and Number | | | 10f. Zip Code | | | 1 | 0g. Citizen of V | Vhat Coun | iry? |
| with with | 822 CHADWICK CIRCLE | | | | 701 | | | USA | | |
| As Should be filed within 72 hours effer death with the Maryland in and Mental Hygiene. 7 is marked other than "netural; or items 23s or 23s-f show traumatic avant, the Maryland Examination must be involved at | 11. Merifel Status 1 Never Married 1 Never Married 2 Married 1 Yes, Girly Year or D | 2X No | | Vas Decedent of Yes, specify Cub | | | | Blac | e - America k, White, e | |
| d 2 should be filed within 72 hours ef th and Mental Hygiene. 7 is marked other than "netural", or traumatic avant, to Medical Exam | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (| 1-4or 5+) | (Give | ent's Usuel Occu kind of work done OO NOT use retire Student | during most ed) | of workin | | 16b. Kind of Bu | siness/Ind | ustry |
| Hygie ther mt, tr | 17. Father's Name (First, Middle, Last) | | | - Coudelle | | r's Name | (First, Middle, I | | a) | |
| should be find Mental Firmarked of | Edgardo Ruiz | | | | | | ILDA PE | | , | |
| CENL | 19a. Informent's Name/Relationship (Type, Print) ELAINE RUIZ / WIFE | | | g Address <i>(Stree</i> CHADWICK | | | | | State, Zip 21701 | Code) |
| -198 | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ♣ Removal from 4 ☐ Donation 5 ☐ Offier (Specify) | State Par | laca of Disposametery, crem | sition (Name of patory or other pla Memorial | Park | 4 | | 20c. Location - Vegabaj | | wn, State uerto Rico |
| permit. Pages Department of Important: If it any Injury or once. | 21. Signatura for Funeral Service Licensee | raytor | L 4 | Name end Addr | land I | Rd. | Suitlar | d, Mary | | |
| Physician | 23a. Part1. Enfer the disease, or complications that of shock, or heart failure. List only one cause on e | aused the death each line. | n. Do not ente | er the mode of dy | ing, such as | cardiac oi | r respiretory err | est, | | Approximate Interval Between Onset and Death |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | Monar | y me | ctustat | ic d | Sca | S | | | 3 years |
| D 5 | not. | astation | Eu | INGS | Savu | SVIC | i | | | 3 years |
| e be axecuted sician and burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | r as a conseq | | | | | | | |
| The law requires that the death certificate be assouted at ans been signed by the attending physician and page 2 should be detached for use as the burial-transit | that initiated events | Due to (or | es a consequ | uence of): | | | | | | |
| death e ath | Part II. Other significant conditions contributing to d | eath but not resu | ulting In the un | iderlying cause g | iven In Part I. | | 23b. Did to | bacco use co | ntributa to | the cause of death |
| thet the ed by th delache | | | | | | 5 | 1 🗆 Y | •• 20 No | 3 Prot | eably 4 Unknow |
| or Attanding Physician: The law requires that the date death. Director: After this cartificate has been signed by the fin by the tuneral director, page 2 should be deleched. | | | | | | | 24a. Wes e | | COI | ore autopsy findings illable prior to impletion of cause deeth? |
| The law ita has bage 2 | | | | | | | 1 🗆 Y | es 2 No | 10 | Yes 2□ No |
| ysician: The last cartificate he director, page | 25. Was case referred to medical | | | | 28. Piace | of Death | (Check only or | ne) | | |
| hysich his car il dirac | examiner? | inpatient 2 1 | ER/Outpatien | 3 DOA | ther: 4 Nu | rsing Hon | ne 5 Reside | enca 8 🗆 Oth | er (Specif) | ') |
| ding Phys h. Aftar this funeral di | 27. Manner of Deeth 1 Natural 5 Pending 28a. Date (Mon | of Injury th, Dey Year) | 28b. Time of Injury | 28c. Inju | ury et ork? | 2 | 8d. Describe h | ow Injury occur | red | |
| tal or Attanding Physician: rs after death. al Director: After this cardificial in by the tuneral director. | 2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Place | | ome, farm, stre | | Yes 2 | | 28f. Location (S City or Town | | per or Flura | l Route Number, |
| To the Hospital or Attanding Physics within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | 29e. Certifier (Check only one) (Check o | best of my knov asis of examinat ner stated. | wledge, death lion end/or inv | occurred at the t estigation, in my | ime, date an opinion, dea | d placa, a | and due to the co | ause(s) and ma late and placa, | inner as st and due to | ated. the cause(s) |
| To the To the compl | 29b. Signature and fifle of certifier | | | | ise number | | 2 | 9d. Dafe signe | | |
| (3) | 30. Name and address of person who completed cause | | 23e) (Type, I | | 21080 | 165 | | 0410 | 12/ | 17) |
| 9 | JAMES G. TAYLOR | 9000 | ROCKV | ILLE PIK | E, BET | THESD | A, MARY | LAND 2 | 20892 | |
| State | | tegistrar's Signat | | | w | | | | | |
| Registra | APR 0 5 1999 | | D. | dones | / | | | | | |
| CE/d Van di navi | | | | | | | | | | |



| | | State of Maryland / Department of Health and I Certificate of Death | | giene eg. No. | 13185 |
|--|-------------------|---|---|---|--|
| Physi /Med | | ALPED DA RELLERE | 2. Data of Daal Month APR • 1 | Day Yaar | 3. Time of Death 3:00 PM |
| Exam Funera Directo | iner 1 | 4a. Facility Nama (If not institution, give street and number) NATIONAL LUTHERAN HOME 5. Social Security Number 1 M 2 F 93 Yrs. 4b. Clty, Town, or I ROCKVI ROCKVI ROCKVI North Hunder 1 Year If Under 24 Hrs. Months Days Hours Min. | LLE 8. Data of Birth (Month, Dev. | 4c. County of Death MONTGOI 9. Birth County 1,1905-Mi | MERY CO. |
| the Maryland 28a-f show | tor | Usual Rasidanca of Decedant 10a. Stata 10b. County MONTGOMERY 10c. City, Town or Location ROCKVILLE | | | 10d. Insida City Limits 1 X Yas 2 □ No |
| death with the Maryland ms 23a or 28a-f show | ai Director | 10e. Street and Number 9701 – VEIRS DRIVE 20850 | 1 | 0g. Citizan of What Cou | intry? |
| - P 4 8 | by Funeral | 3 □ 3 □ Widowed 4 □ Divorced Year or Dates: VAKNOWN 1 □ Year 2 □ XNO Spacify: | pecify Yas or No- o Rican, atc.) | 14. Raca - Amar Black, Whita Specify: WH] | , atc. |
| vithin 72 within 72 ene. then "nat | Completed | 15. Decedant's Education (Specify only highast grada complated) Elementery/Sacondary (0-12) 16a. Dacedant's Usual Occupation (Give kind of work done during most of work | king | 16b. Kind of Business/li | WAREHOUSE |
| aryland 2121 should be filed within a Mentel Hygiene. marked other then imetic event, me Me | To Be Co | 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nam 18. Mothar's Nam | na (First, Middla, M GARET K | Maidan Sumama) | |
| re, Maryla s 1 end 2 should f Health and Mer them 27 is marks | | 19a. Informant's Name/Raiationship (Type, Print) REV • DR • REICHARD – EXECUTOR 19b. Meiling Addrass (Street and Number or Ru 9701 – VEIRS DR 20a. Mathod of Disposition 20b. Placa of Disposition (Name of | IVE., R | OCKVILLE, | MD.20850 |
| Itimo | | 1 X Bunal 2 □ Cremation 3 □ Bamoval from Stata camatary, cramatory or other place) | | 20c. Location - City or T GLEN BURN | |
| Ba Depa Impo | | HYSONG CO., INC 1300- N ST., NI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List boy one cartiss on each line. | C. W. WASH | . DC | Approximate |
| Physiclar /Medica Examiner | | Immediata Causa (Final disaasa or condition resulting in daath) Preumonia Due to (or as a consequence of): | | | Intarvet Between |
| . Box 68760, deeth certificate be executed e ettending physician and of or use as the buriel-trensit | edical Examiner | Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted avants rasulting in death) Last Due to (or as a consequence of): | | | |
| deeth certifie e ettending od for use e | Physician/Me | | 23h Did to | bacco use contribute | to the cause of death? |
| cords, P.O. requires that the desen signed by the hould be deteched | by | The tall the traction | 1 - Y | | bably 4 Unknown |
| 2 8 8 8 | Completed | #SCUD | 24a. Was ai perform | ned? | fere autopsy findings vallable prior to ompiation of causa daath? |
| of Vital Re Physician: The la this certificate he ral director, pege | Be | 25. Was casa rafarrad to medical axaminar? 26. Placa of Daa | 1 ☐ Ya | e) | □Yas 2□No |
| After fune | Certification: To | 1 inpatiant 2 Et/Outpatient 3 DOA 4 Nursing H | oma 5 ∐ Rasida 28d. Dascribe ho | nca 6 □Othar (Speci ow injury occurred | fy) |
| Division To the Hospital or Attending within 24 hours eiter death. To the Funeral Director: Afte completely filled in by the fune | | | City or Town | use(s) and menner as | stated |
| To the Hos within 24 h | Medical | (Check only one) 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occur and mennar stated. 29b. Signature and title of certains. | rred at the tima, da | ata and plece, and due to | o tha cause(s) |
| (4) | | 39. Name end address of person who combleted causa of death (Item 23a) (Type, Print) | Rd | German | toan, mp |
| St Regist | ate rar | 31. Data filed (Month, Dey, Year) APR 0 5 1999 | (| | |

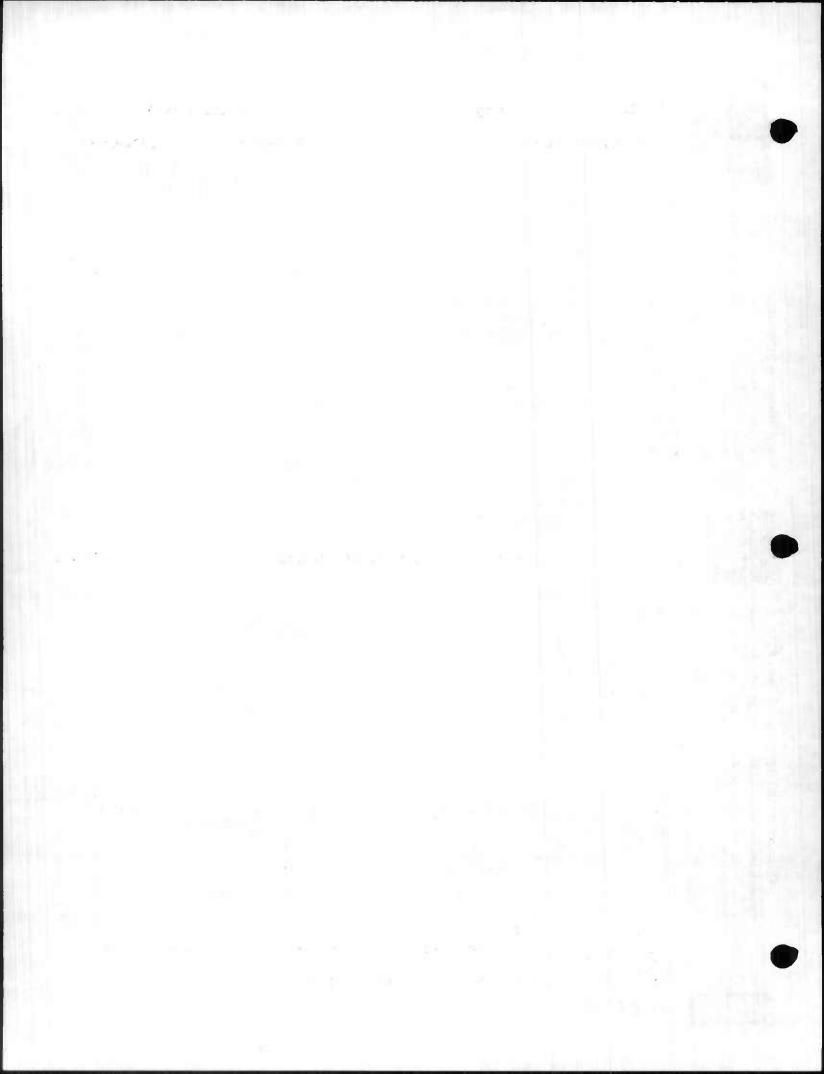
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Dey **Physician** Charles R. Rapp Jr. April 3 1999 7:56PM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Memorial Hospital Cumberland **Allegany** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) 928 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** 1**⊋**M 2□ F Months Deys 208-20-2487 70 Yrs. Director Usual Residence of Decedent the Manylend 10c. City, Town or Location 10d. inside City Limits 10a State 10h County 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Wool or Examiner must be notified at 1 Yes 2 No Cumberland Directo MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

nt: If Nem 27 Is marked other than "natural", or itema 23a or? 14901 N. Bel Air Drive 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? ★□ Yes 2 □ No If Yes, Give Year or Dates:1953 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. t Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes → □ No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Courier Smith I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) retired and Nephew Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles R. Rapp, Sr. Camille (Rihn) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 14901 N. Bel Air Dr.; Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Pnint) Loretta Rapp 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cem4/08/ Flintstone, MD 21. Signature of Funerel Service Licensee 2Scarpers Funeral Home P.A. Cumberland, Maryland 21502 23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediete Cause (Finel diseese or condition resulting In deeth) /Medical Arteriosclerotic heart disease Uk yrs Examiner Due to (or es a consequence of): Examiner that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as e consequence of): pue physician Physician/Medical the Due to (or as a consequence of) SS USB USB Pol signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? peen page 2 has 2 No 1 ☐ Yes 2 ☐ No cartificate Nospital or Attending Physician: 24 hours after deeth. Funeral Director: After this carifica director, 25. Was case referred to medical Be 28. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2X ER/Outpetient 3□ DOA funeral Menger of Deeth 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 ☐ HomicIde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical completely To the Vithin 2 29b. Signetury and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dpty Med Ex D 09157 April 3 1999 who completed cause of deeth (Item 23e) (Type, Print) ess of person Paul Snow, M.D. 124 w 3rd st Cumberland Md 21502 nx APR 0 6 1899 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

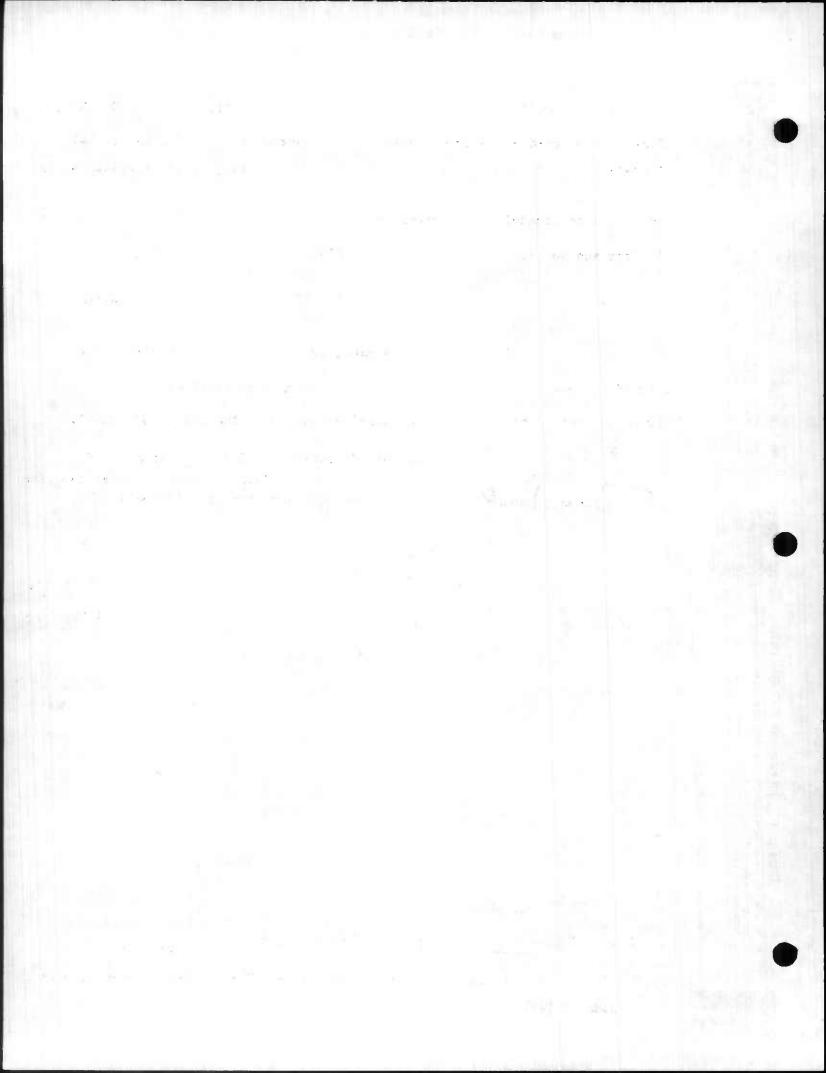


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Wilford Charles Scott April 5 1999 9:10 AM · /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Spa Creek Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 17,1912 Pennsylvania 5. Social Security Number If Under 24 Hrs. 6. Sex 1 XM 2 ☐ F **Funeral** Months Days Hours Min 255-07-1912 86 Yrs. Director Usual Residence of Decedent the Merylend 10c. City, Town or Location 10d. tnside City Limits 10e State 10b County 7 is marked other than "naturel", or items 23s or 28s-f show traumstic avent, the Modical Examinat must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21403 308 Carriage Run Rd. USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Peges 1 end 2 should be filed within 72 hours efter lent of Heelth end Mentel Hygiene. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ, White 3 ☐ Widowed 4 ☑ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Public Works 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Be Sara Jane Williams Wilford L. Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Heelth e If item 27 is or other tra Wilford W. Scott / son 308 Carriage Run Rd. Annapolis, Md. 21403 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or 4-6-99 Ft. Lincoln Crematory Brentwood, Md. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Servica Licent 147 Duke of Gloucester St. Annapolis, Md.21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** & weeks /Medical Immediate Cause (Final neumonia disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Jement a law requires that the death certificate be executed sician end burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Employeema physician (Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Insufficien 189 esu Renal ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed I PV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 MNo 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours effer deeth. Funeral Director: After this certific director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D40519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 OAKWOOD PROF, BLAG. Glen Berine MIRZA M. NUSAIREE. 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State APR 0 6 1999 Registrar

DHMH 16 Ray 6/95



99-2005-013 jhm BILL EUGENE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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| Funeral Director | 5. Social Security N 411-54- | 7237 | Sex 11X7M 2□F | 7. Age (In yrs. 64 | lest birthday) Yrs. | If Under 1 Months | | If Under Hours | 24 Hrs. Min. | (Month, L | irth lay, Year) 1935 | Cou | place (Stata or Foreign ntry) NESSEE |
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| There death with the Ma there 23a or 28a-f a infer must be notified Forward Director | 10e. Street and Nur 508 POP | | | | | 10f. Zip C | | | | | | Citizen of What Country? USA | |
| Dy Ext. | 3 ☐ Widowed | ied 21 Married 4 □ Divorced | Armed F | edent Ever in U orces? 2 No KO we Datas CONF | REAN | Vas Decede I Yes, specif I 🗆 Yes 2[| | | | pecify Yes or No Rican, etc.) | Spec | ace - Ameri lack, Whita, cify: WHI | , etc. |
| 72 ho | (Spec | 15. Decedent's E | ducation ade completed) | | 16a. Deced | lent's Usual kind of work OO NOT use | Occup | etion during mo: | st of work | king | 16b. Kind of | Business/Ir | ndustry |
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| 2 sh and is m | 19a. Informant's Na | | | | 19b. Mailir | g Address (| Street | and Numb | er or Rui | ral Route Num | ber, City or Tox | m, Stata, Zi | p Code) |
| semit. Pages 1 and Apartment of Health mportant: if item 27 my injury or other t 000s. | | osition Cremation 3 E | Removal from | State | Place of Dispo cemetary, cren | sition (Name natory or oth | of er plac | 00) | | Data | 20c. Locatio | n - City or T | |
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| Depa Depa Impo any is | 21. Signature of Fu | am Sarvice Lice | Mus | Howa | 4 | Name and 54 E. | | | . I I | | R FUNE | | HOME D. 21157 |
| certificate be executed noting physician and use as the burial-transit | Sequentially list co if any, leading to in causa. Enter Unde Cause (Disease or that initiated avants rasulting in death) I | nditions, madiata rtying injury | b | Due to (c | or as a consequence as | uence of): | | | - | | | 1 | |
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| T d die ph | 27. Mannar ot Death | examinar? **To Yas 2 \(\text{No} \) Hospitat: 1 \(\text{Inpetient} \) 2 \(\text{ER/Outpatient} \) 3 \(\text{DOA} \) Other: 4 \(\text{Nurs} \) Nurs 27. Mannar of Death 1 \(\text{Natural} \) 5 \(\text{Pending} \) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury with Work? | | | | | | | | | how injury occ | curred | ty) SCENE |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Car In Parting 10 F Carroll (0 | | | | | | | | | | (Street and Nur own, State) 2 | mber or Rui | |
| ne Hospitu ne Funera pletely fille | 29a. Certifier (Check only one) | 1 Certifying Pt 2 Medical Exar | ysician: To the | best of my kno | wiedge, death | occurred at | the tir | ne, date a pinion, de | nd place, | and due to th | a cause(s) and | manner as | stated. to the cause(s) |
| To the within To the comp | 29b. Signatura and | titla of certifier | 1 | 1 | 1- | | | e number | | | 29d. Data sig | | |
| , | 30. Nama and addre | ass of person who | completed cause | se of death (Item | 23a) (Type | | OCIV | تبر | | | WLUTP | 00, 1 | 223 |
| | Strone | | | | 111 P | enn St | rec | et, B | altir | more, M | laryland | 1 2120 | 1 |

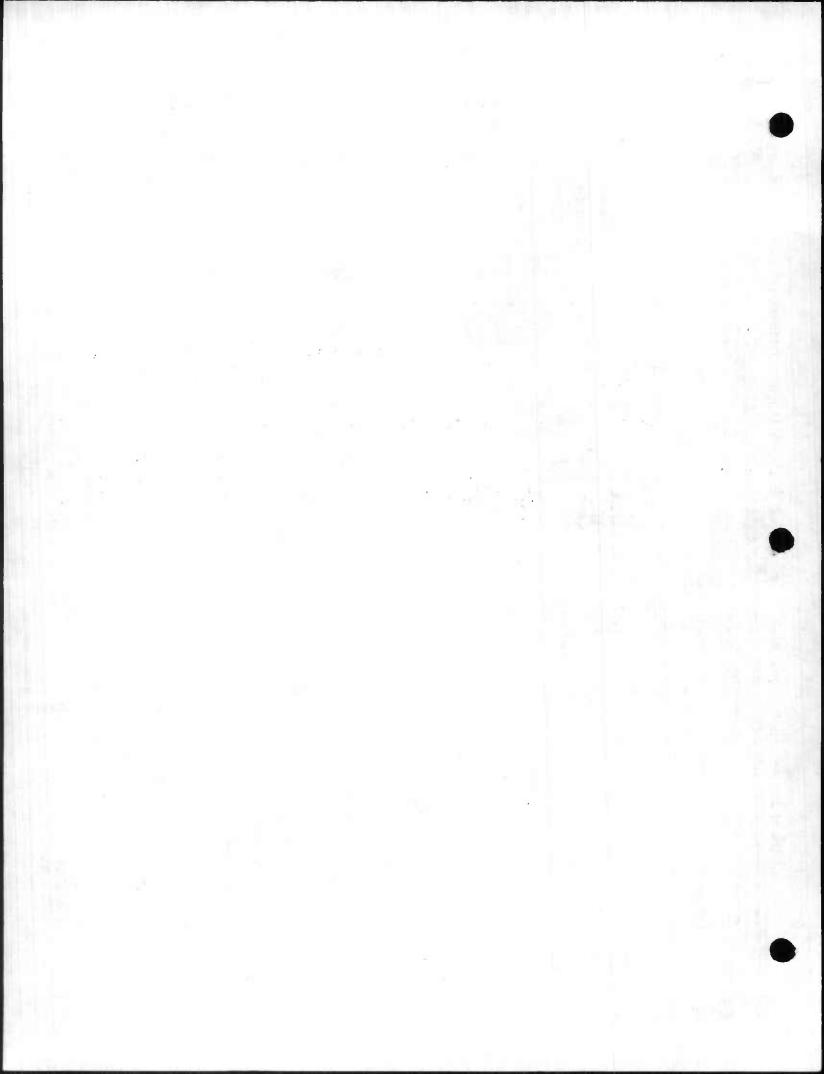
State Registrar

Stephen S. Radentz,

31. Data filed (Month, Day, Year)

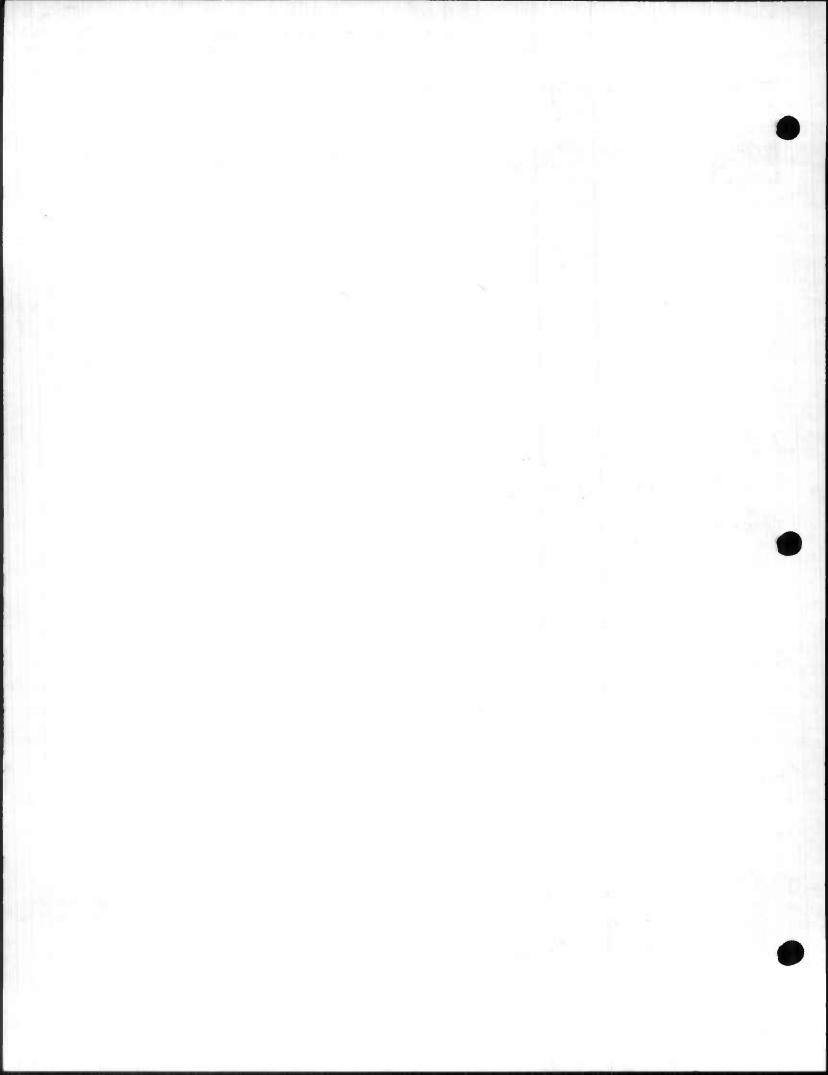
32. Registrar's Signature

Sporks



State of Maryland / Department of Health and Mental Hygiene

| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death 1 | | | | | | | | Ce | ertifica | ite of | Death | | Re | g. No. | | | |
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| Physician //Medical Examiner The Class of Control of | | | | stybok ground | ure. List of | mplications thet ly one ceuse on | eech line. | eeth. Do not er | iter the mo | de of dyl | ng, such es | cardiec | or respiretory erre | st, | 1 | Approxime intervel Be | ete etween |
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| Dr. Patrick A. Turnes 1425 Liberty Road Eldersburg, Maryland 21784 | | | | Jares | 01/ | aurege | 4 | | | D | 20806 | | | | 4/5/ | 99 | |
| Of Day Blad Black Day Visit | | | 11 | 30. Name ^l end eddr | | | | | | | | | | | | | |
| State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture | | | | Dr. Patrick | A. Turnes | 1425 Liber | ty Road | Eldersburg | , Maryl | and 2 | 1784 | | | | | | |
| | | Sta | te | 31. Dete filed (Mon | th, Dey, Year) | 32. | Registrer's Si | gneture | | | | | | | | _ | |



| 1. Decedent's Name (First, Middle, L. | (and) | Ce | rtificate of | Death | 2. Dete of Dee | Reg. No. | 3. Time of Deeth |
|---|--|--|--|--|--|--|---|
| David Ja | mes | | II | | Month APRIL | 02 19 | 999 15:16 PM |
| er Sacred Heart Ho | | | | 4b. City, Town, or Cumberla | | 4c. County o | |
| 5. Social Security Number 6. 579–72–3991 | Sex 7. Ag | ge (In yrs. lest birthdey) 45 Yrs. | If Under 1 Year Months Deys | | 8. Date of Birth | , Year) | 9. Birthpiece (State or Foreign Country) Ashington, D.C. |
| Usuel Rasidence of Decedent 10e. Stete 10b. County | | 10c. City, Town or Lo | ncation | | | | 10d. Inside City Limits |
| | 137 | Cumberl | | | | | 1 XYes 2 No |
| Maryland Allegan 10e. Street and Number | . 9 | Oumberr | 10f. Zip Code | | | 10g. Citizan of Wi | hat Country? |
| | Highway | | 21502 | 2 | | United S | States |
| 13800 McMullen 11. Manitel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 | No | Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No | Hispenic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No- o Rican, etc.) | 14. Rece Black Specify: | - American Indien, K, White, etc. African- American |
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| David James Smi | | 4.004 6.4 *** | an Address (O) | | Mason | City and Town | State Zin Code) |
| 19e. Informent's Name/Reletionship Eleanor Virginia | | | | tand Number or Ri Rd. #T2 C | | | MD 20743 |
| 20e. Method of Disposition | | 20b. Plece of Dispo | | 1 | Data | | City or Town, State |
| 1 Suriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec | | | Memoria | | 4/13/99 | Landover | r, Maryland |
| 23ii. Parti botter the disease, of contents of heart feilure. List only immediate Ceuse (Final disease or condition resulting in daath) | e. He | batic | quence of): | mo | | 10 | Intervel Between Onset and Death |
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Registrar

| State of Maryland / Department of Health and Mental | Hygiene (| 1 | 2 | 1 0 | |
|---|-----------|-------|---|-----|--|
| Certificate of Death | Reg. No. | 2 . 1 | 3 | 1 7 | |

3. Time of Death

Birthpiace (State or Foreign Country)

10d. fnside City Limits

Approximate Interval Between Onset and Death

24b. Were eutopsy findings available prior to completion of cause of death?

1.2 Yes 2□ No

0

1₺ Yes 2□ No

Brooklyn, NY

White

11:45 A.M.

| Discontinue |
|-------------|
| Physician |
| /Medical |
| Examiner |

2. Date of Deeth 1. Decedent's Name (First, Middle, Last) March 22, 1999

Af Death 4c. County of Death EDWARD JOSEPH STANTON JR. 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 8705 Brand Court Clinton
If Under 1 Year | If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Dey, Year) 10-8-15 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours Min 12⊠M 2□ F Yrs. 83 Director 065-09-2883 Usual Residence of Decedent with the Marylend 10e. Slete 10b. County 10c. City, Town or Location ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Directo Maryland Prince Georges Clinton 10g. Citizen of What Country? 10e. Sireel and Number 10f. Zip Code 20735 USA 8705 Brand Court Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritai Slalus d 2 should be filed within 72 hours after th and Mental Hygiene.
7.7 is marked other than "netural", or the traumatic event, the Medical Evantine. 1 Tyes 2 No If Yes, Give Yeer or Dates: 1942-46 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense 12 Electronics 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Margeret Snyder Edward Stanton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If item 27 is m any injury or other traum once. 8408 157th Ave., Howard Beach, NY 11414 Harold Stanton 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stale 20a. Method of Disposition 1XX Buriei 2 ☐ Cremation 3 ☐ Removal from State 4-1-99 Quantico, VA Quantico National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Strickland Funeral Services, PA 6500 Allentown Rd, Camp Springs, MD Herry 23á. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Contact gunshot wound of head **Examiner** Due to (er as a consequence of): Examine physician end s the burial-transit the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Ihal initiated events resulting in death) Last Due to (or as e consequence of): 88 for use as signed by the e 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown The law requires that by been sig Completed 24a. Was an autopsy performed? nis certificate has b 2 imited 10 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛱 Residence 8 ☐ Other (Specify) XX Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) Feun C 3-23-99 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 Yes 2 No death. investigation subject shot self ector: untrown 2 Accident 6 Could not be determined 3 X Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) & 705 Brand Count 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter 6 filled in Residence Prince Georges Lounty, Mary) and Hospital 24 hours 29a. Certifier edicai completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner staled. (Check only one) To the I within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number March 23, 1999 O.C.M.E.

State

Registrar

Radentz 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ush

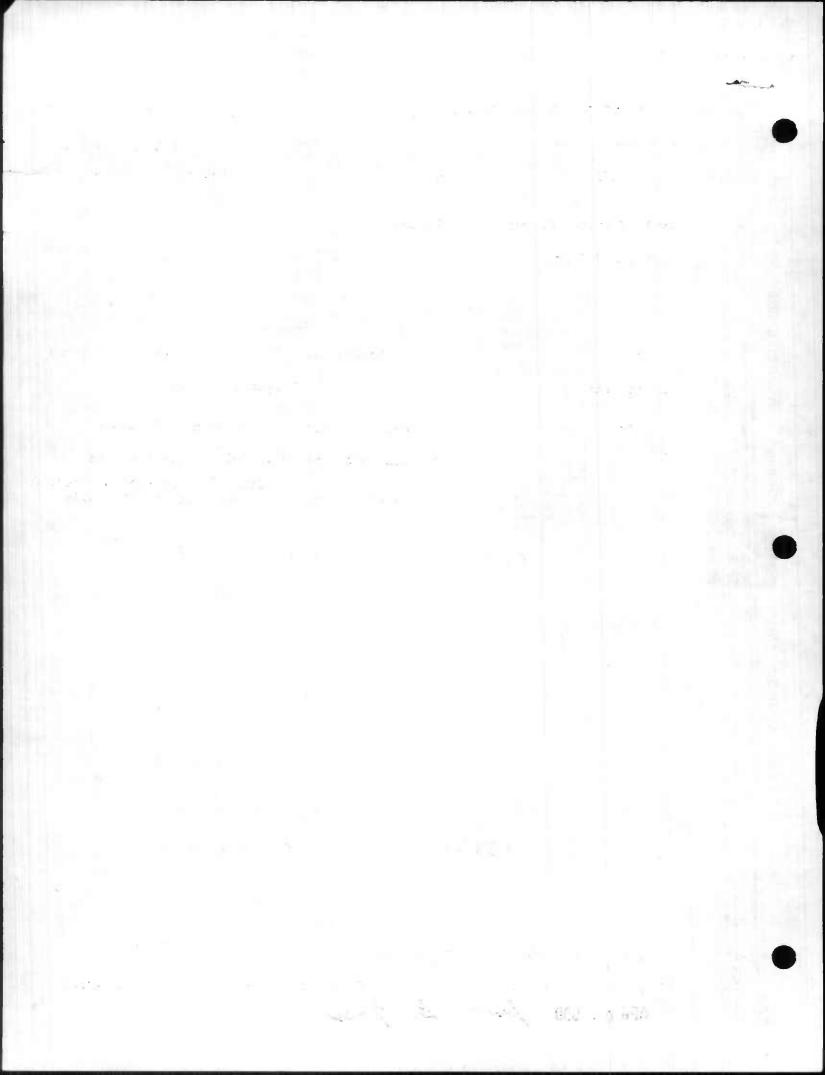
APR 0 6 1999

5,

Stephen

31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201



2001 HOSPITAL PRIVE, CHEVERLY, MARYLAND 20785

| | | epin a pro-est | | | Cer | шиса | ie oi | Death | 100 | Reg. No. | | lana of Carat | |
|---|--|---|--|---------------------------------|-----------------------------------|-----------|------------------------|---|-----------------------------|---------------------------------|---|-------------------------|--|
| Physician | 1. Decedant's Nama | | | | | | | | 2. Data of D Month | Day | Year A | ime of Death | |
| /Medical | - | lexande | | | | | | 4b. City, Town, or | MARCO | | 199 0 | 100 | |
| Examiner | 4a Facility Name (If n | O CAST | | WENU | = #LU | 2 | | CAO | .1 | . 00 | NCE GEO | WIL | |
| | 5. Social Security Num | mber 6. | - 1 - / | | last birthday) | If Unde | er 1 Yaar | if Undar 24 Hrs. | L HEIGH | | 9. Birthplaca (S | State or Foreign | |
| eral ctor | 226-34-28 | 04 | Sex 12M 2□F | 65 | Yrs. | Months | Days | Hours Min. | 8. Data of B (Month, D | ay, Year) 0. 1933 | Virginia | | |
| | Usual Residence of D | | | | | | | | | | | | |
| by Funeral Director | 1000000 | 10b. County | | 10c. C | lity, Town or Lo | cation | | | | | | Ida City Limits | |
| ct | Maryland 1 | | George's | Ca | pital H | | | | | | |]Yes 2□No | |
| F | 10e. Street and Numb | | " | | | | ip Coda | | | 10g. Citizan of | What Country? | | |
| rai | 505 Suffo | lk Aven | | 4 F | 10 40 1 | | 743 | liana de Orlaino (C | it . V N | U.S.A. | e - Amarican Indi | 0.0 | |
| nu. | 11. Marital Status | 4 00 Mandad | 12. Was Deced | cas? | U,S. 13. V | Yas, sp | ecify Cub | lispanic Orlgin? (S an, Maxican, Puart | o Ricen, atc.) | O- 14. Had Bla | ck, White, etc. | an, | |
| Completed by Funeral Director | 1 ☐ Navar Marriad | T.A. | 1 X Yas 2 If Yes, Give Year or Da | 9 | 1 | ☐ Yas | 2 No | Specify: | | Specif | Black | | |
| | 1 | 5. Decedant's E | | | 16a. Deced | ent's Us | ual Occup | pation | | 16b. Kind of B | usinass/Industry | | |
| pie | (Specify | only highest gr | rade complatad) Coilege (1- | 40r 5±\ | (Giva | kind of w | ork done usa retire | during most of word) | rking | | | | |
| S. | 12 | 20.7 (0 12) | oonogo (1 | | Self- | Emp1 | Loyed | l | | Mail Or | der Busi | iness | |
| Be | 17. Father's Nama (F) | irst, Middle, Las | t) | | | | | 18. Mothar's Nar | ne (First, Middle | a, Maiden Sumar | ne) | | |
| To Be Completed | Sidney A. | Seward | , Sr. | | | | | Alice W | alston | | | | |
| | 19a, Informant's Nam | | | | | | | and Number or Ru | | | | | |
| | Tracy M. | | Daughte | | | | | treet, No | | | | | |
| ei ei | 20a. Mathod of Dispos | | ☐Removal from S | itata | Place of Dispo- cematary, cran | natory or | othar ple | | Data | | City or Town, Sta | | |
| | 4 Donation 5 | | | Qu | | | | Cemetery | 04/05/99 | Triang | e, Virgi | inia | |
| cian lical iner | Immediata Causa (Fi diseasa or condition resulting in deeth) | inal | a AFTER | | AFOTIC (or es a conseq | | | IVASCULA | R DIS | EASE | i | t and Death | |
| Examiner | Sequantially list cond if any, leeding to Imm ceuse. Enter Underly Causa (Disaase or In | ditions, | b | Due to | (or es a conseq | uence of |): | | | | | | |
| edical E | cause. Enter Underly Causa (Disaase or In that initiated events rasulting in death) La | | C | Dua to | or es a consaq | uence of |): | | | | | | |
| Physician/Me | | - | d | | | | | | | | | | |
| detached Physic | Part II, Other significa | ant conditiona | contributing to dea | ath but not ra | sulting in tha ur | ndarlying | causa giv | van in Part I. | 23b. Dlo | i tobacco use co | entribute to the ca | ause of death? | |
| | | | | | | | | | 1 | Yes 2 No | 3 ☐ Probably | 4 Unknow | |
| Completed by | | | | | | | | | | s an autopsy formad? | 24b. Wara auto availeble completio of death? | prior to on of ceusa | |
| Com | | | | | | | | | 1 | Yas 2 No | 1 ☐ Yas | 2□ No | |
| BeC | 25. Was cesa referra | d to medical | | | | | | 26. Placa of Da | ath (Chack only | ona) | | | |
| To Be | exeminar? 1 X Yas 2 □ No | 0 | Hospitei: 1 ☐ In | patiant 2[| ☐ ER/Outpatien | t 3 🗆 E | Oth Oth | ner: 4 - Nursing H | ioma 5 Ras | sidance 6 🗆 Ott | 6 Other (Specify) | | |
| | 27. Menner of Death 1 Natural | 28b. Time of Injury | Time of 28c. Injury at 28d. Describe how injury occurred | | | | | rred | | | | | |
| ne fur | 2 Accidant | 5 Panding investigation | | | | | | reet, fectory, office 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) | | | | | |
| opistoly filled in by the fur fedical Certificatio | | | 28a. Place o | of Injury - At g, atc. (Spec | home, ferm, stre | | ory, office | | 28f. Location City or To | (Street and Num. own, Stete) | ber or Rural Route | a Number, | |
| Æ | 2 Accident 3 Suicide 4 Homicide | investigation 6 Could not to datamined | 28a. Place of building | g, atc. (Spec | cify) | occurre | d et the ti | me, dete end place | City or To | own, Stete) e ceuse(s) end m | enner as steted. | | |

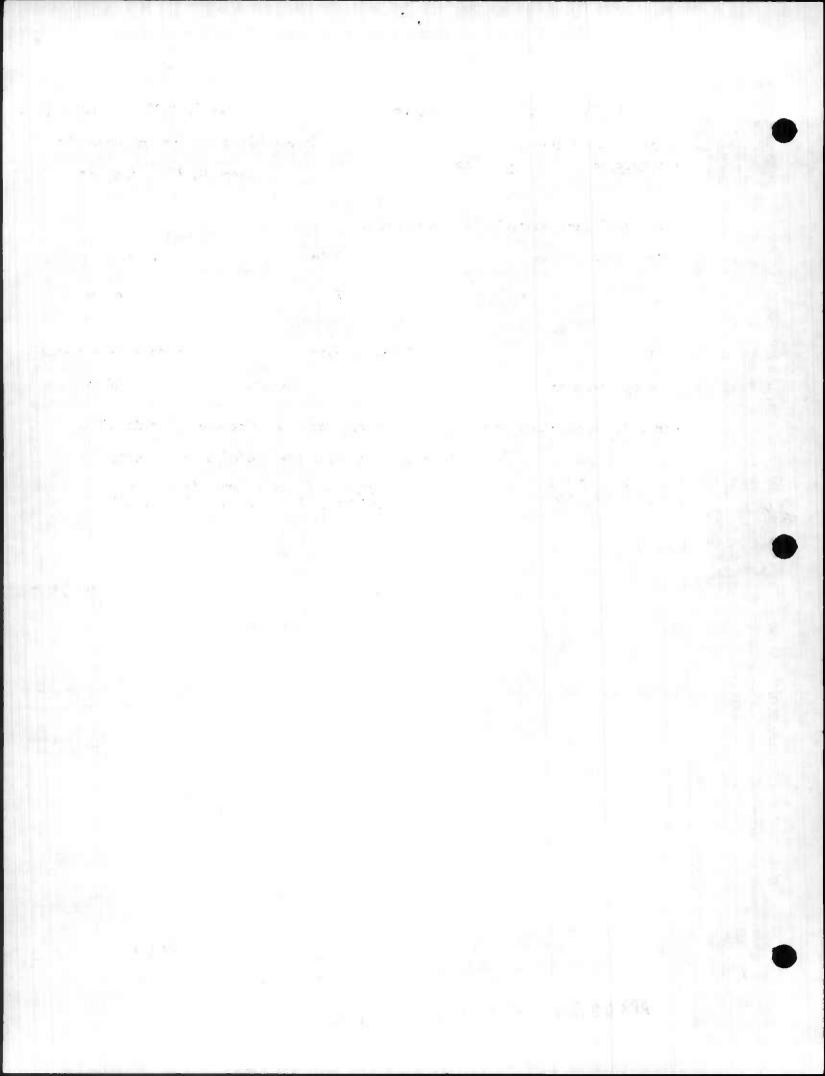
State · Registrar

APR 0 6 1999

028 + 0.394

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 1. | Decedent's Nen | ne (First, Midd | die, Last) | | | | | | | | 2. Dete of D | | | | ime of Death |
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| ician | ١. | ጥ፥ | llie | K | | | Chanin | | | | A | Month pril (| Dey 5, 1999 | | ar 10 | 10 P.M |
| dical niner | 40 | Fecility Name (| | | | | Shapir | Q | | 4b. City, Tov | vn, or Loc | ation of Dea | | | | IO I .I |
| ier | | | | | | | | | | Temp1 | | | | | George | 10 |
| | | 4003 Social Security I | 28th A | 6. Sex | | 7 Age (In vrs | s. last birthdey |) If Und | er 1 Year | If Under 2 | 24 Hrs. | 8. Dete of Bi (Month, D | irth | | | |
| l r | 1 | 110-09-5 | 5235 | | M 20XF | 88 | Yrs. | Months | Deys | Hours | Min. | (Month, Darch 8 | , 1911 | Ne | 9. Birthplece (State or Foreig Country) New York | |
| | - | e. Stete | 10b. County | у | | 10c. C | City, Town or L | ocation | | | | | | | | side City Limit |
| Director | N | Maryland | Princ | e Ge | eorge's | T | Cemple | Hills | S | | | | | | 1[| JYes 2∭ N |
| ire. | 10 | e. Street and Nu | ımber | | | | | | ip Code | | | | 10g. Citizen | of Whe | t Country? | |
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| Funeral | 11 | . Maritel Status | | | | dent Ever in | U,S. 13. | . Wes Dec | edant of h | Hispenic Orig | in? (Spe | city Yes or N | 0- 14.1 | | American Ind White, etc. | dian, |
| by Fu | | 1 ☐ Never Man 3 ☐ Widowed | | | 1 Tes If Yes, Giv Yeer or D | 2 XNo | | | | Specify: | | noon, aron, | | | White | |
| | | | 15. Decede | nt's Educ | cetion | | 16e. Dece | edent's Us | uel Occup | pation | | | 16b. Klnd o | f Busin | ess/Industry | |
| plet | - | | cify only high | est grade | completed) | | (Give | e kind of w DO NOT | vork done use retire | during most | of working | 99 | | | | |
| mo | | Elamantary/Sec 12 | ondary (0-12) | | College (1 | -40r 5+) | Offi | ice Ma | anage | er | | | Fede | ral | Gover | nment |
| Be Completed | 17 | . Fether's Neme | (First, Middle | , Last) | | | | | - 0 | | r's Name | (First, Middle | e, Maiden Sun | | | |
| To B | | George | Krasn | ner | | | | | | Unk | nown | | | J | Unknow | n |
| F | | e. Intormant's N | | | pe, Print) | | 19b. Mail | iling Addre | ss (Street | 1 | | Route Numi | ber, City or To | | | |
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| | 20 | Doris D. e. Method of Dis | onap1 | ro/l | augnte | 20b. | Plece of Disp cemetery, cre | cosition (N | eme of | Jous D | 1.0 | r Lando Dete | Flor | | y or Town, S | |
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| | | 1/1/10 | 1000 | w | | | | | | | | | | | | |
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| | | 3e. Pert1. Enter shock, or he | the diseese, c ert teilure. Lis | or complic st only on | cations that c | aused tha decech line. | eth. Do not er | nter tha mo | oda of dyl | ing, such as | Kd. | raspiratory | arrast, | שעי ב | Appr | oximete val Between et end Deeth |
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 9:10 PM 1999 APRIL Mary Claire Smith /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, give street end number) 4c. County of Deeth Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2\ F Months Yrs. 203-24-9754 69 March 30, 1930 Director Pennsylvania Usual Residence of Decedent the Marylend permit. Peges 1 end 2 should be filed within 72 hours effer death with the Marylen Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or flams 23a or 28a-i show any Injury or other traumatic event, the Mexical Examines must be norfiled at each. 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 Yes 2 □ No Directo Maryland | Prince George's Cheverly 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Coda 2805 63rd Place 20785 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marifel Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 🎇 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's County Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Purchasing Agent Health Department 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Brink Clarence Mary Catherine McHugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mauri Smith - Daughter 5830 Dewey Street, Cheverly, Maryland 20785 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Bunal 2 □ Cremetion 3 □ Removel from State Gate Of Heaven Cemetery 104/10/99 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final Brain Stem Stroke disease or condition rasulting in death) Examiner Examiner cipital physician and the buriel-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. PSiS Physician/Medical Due to (or as e consequence of) 9 for use es signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O 1 Yes 2 No 3 Probably 4 Onknown Records, P. The law requiras that by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed is certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital I or Attending Physicien: after death.
Director: After this certifica Be 25. Was case refarred to medical 26. Piece of Deeth (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending investigation 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 29a. Certifier 1 Cartifying Phyalclen: To the best of my knowledge, death occurred et the time, date end place, and due to tha cause(s) and mannar as stated. Medical 2 Medical Examinar: On the besia of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature find title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 00053733 MA 30. Name and eddress of parson who complated causa of death (Item 23a) (Type, Print) LAKHANPAL, N.D. HOSPITAL DRIVE CHEVERLY, MD 20785 22. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Yaar)

APR 0.9 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Katherine Elizabeth Smallwood 1999 13:09AM April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | June | 17, 1920 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 DM 2 F 216-22-0344 78 Yrs. Maryland **Director** Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 Metzerott Road 20783 United States permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 IXNo Specify: Black Specify: If Yes, Give Yeer or Dates þ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Cafeteria Worker Government 17. Felher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Gross Edna Ross 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Estelle Falwell - Sister 4221 Eads St., N.E. Wash., D.C. 20019-3440 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stale 20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4/9/99 Harmony Memorial Park Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Fecility Stewart Funeral Home alesan 4001 Benning Rd., N.E. Wash., D.C. 20019 0 23a. Part). Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Endocartis weeks Examiner Due to (or es e consequence of): Corelors Vascular accid Examin physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in deeth) Lest 10 attending p for use as tarler signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed certificate has t 200 No 1 Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Reeldence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Date of Injury Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Netural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Dey, Yeer)
APR 0 5 1999

SA MEH

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

481 N. Fredorick Ave. #230 Gauthersburg MD 20877

And the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Day Year JASMINE LORING SKEETE 1999 APRIL 4:20 PM 4b, City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Death National Institutes of Health Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) Days Months 1 M 2 G/F 01862-7945 17 Yrs. MAY 14, 1981 BOSTON, MASS Usual Residence of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No Virginia Fairfax Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8075 Sebon Drive 22180 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritei Status Bleck, White, etc. BIRACIAL 1 Never Married 2 Married 1□ Yes 2√ No Specify. Specify:Black/White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etemantary/Secondary (0-12) Cotlega (1-4or 5+) Student PVT. 11th 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) WALTON SKEETE PAMELA LORING 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAMELA LORING/ MOTHER 8075 SEBON DRIVE VIENNA, VIRGINIA 22180 20b. Piace of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State 4-8-99 LYNWOOD CREMATORY HAVERHILL, MASS. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture/of Funeral Service Licensea Marshall's Funeral Home of Md Mawai 4308 Suitland Rd. Suitland, MARYLAND 20746 23a. Pert1. Enter the disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death immediate Cause (Final disease or condition rasulting in daath) · Pulmonary metastases Dua to (or as a consequence of) Wilms tomor Vietustatic anaplastic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in deeth) Last Dua to (or as a consaduenca of): Due to (or as a consequence ot): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2No 3 Probably 4 Unknown anticoaculant 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ∏Yes 2 ∏ No 25. Was case reterred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, atc. (Specify) 4 T Homicida

the death certificate be executed Division of Vital Records, P.O. Box 68760. this

Examiner physician and the bunal-transit Physician/Medical as for usa signed by the a Completed s certificate has b director, page 2 s or Attending Physician: funeral director, Certification: To 24 hours after death. Funeral Director: A filled in by

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "---- and injury or other traumest."

/Medical

10a. State

To the Hosp within 24 hor To the Fune completely fi Registrar

State

JAMES G. TAYLOR 31. Date filed (Month, Dey, Year) APR 0 5 1999

29a. Certifiar

(Check only one)

29b. Signeture and title of certifier

ChriMO Clinical Fellow 30. Name and address of peccon who complated cause of death (Item 23a) (Type, Print) 32 Registrar's Signature



Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to the causa(s) and manner as stated.

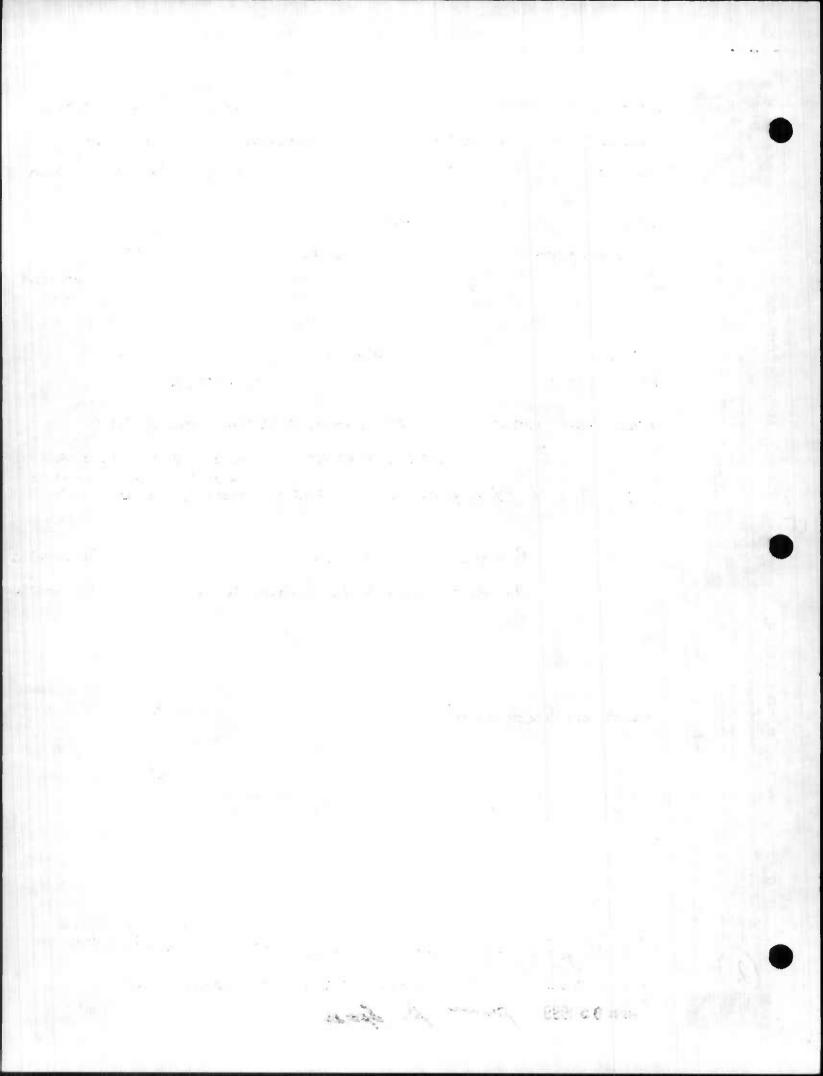
Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) end menner stated.

29c. Licanse number ...

MD108463

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Eleanor Arbutus Sollars 7, 1999 April 10:50a.m 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Dennett Road Manor Nursing Home Oakland If Undar 24 Hrs Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1□ M 200 F Months Hours 77 216-66-0816 Mar. 16, 1922 West Virginia Usual Residence of Decedent 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yas 2X No Mineral Elk Garden 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 26717 P O BOX 173 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Was Dacedant Evar in U,S Armed Forcas? 11. Marital Status Biack, Whita, atc. ☐ Yas 2 No f Yas, Giva 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 ₩idowed 4 Divorcad Yaar or Datas: 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 9th. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Wesley Shillingburg Rhoda Streets 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) Janet Harding (Daughter) HC 76 Box 38, Mount Storm, WV 26739 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Queens Point Cemetery 4/10/99 Keyser, West Virginia 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Markwood Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirely errest, WV shock, or heart failure. List only one cause on each line. 26726 Approximata Interval Batween Onsat and Death atherosclerotic cardiovascular disease Immadiata Causa (Final 6 months disaase or condition resulting in death) Due to (or as a consequance of): Sequantially list conditions, if any, laeding to immediata causa. Entar Underlying Cause (Disaasa or injury that initieted events Dua to (or as a consequence of) that initieted events rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown diabetes mellitus type 2, hypertension 24b. Wara autopsy findings svailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa rafarred to medical axaminar? 26. Plece of Deeth (Check only one) Other: Nursing Homa 5 Assidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 28c. injury et Work? 28b. Tima of 28d. Dascribe how Injury occurred 1 Natural 2 Accidant

physician and s the bunal-transit requires that the death certificete be executed Division of Vital Records, P.O. Box 68760 attending p esn the signed by the should ! s certificate has be director, page 2 s Hospital or Attending Physician: '24 hours efter death.
Funeral Director: After this certifica director, To the Hospital or Attending Phy within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral

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Pages 1 end 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
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permit. Page Depertment of important: If any injury or once.

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Baltimore, Maryland 21215-0020

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Physician/Medical by Completed Be 2 Certification:

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29a. Cartifian

4 Homicide

5 Panding invastigation

6 Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete)

TE-certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

unes

D25759

29c. Licanse number

29d. Data signed (Month, Day, Year) April 7, 1999

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

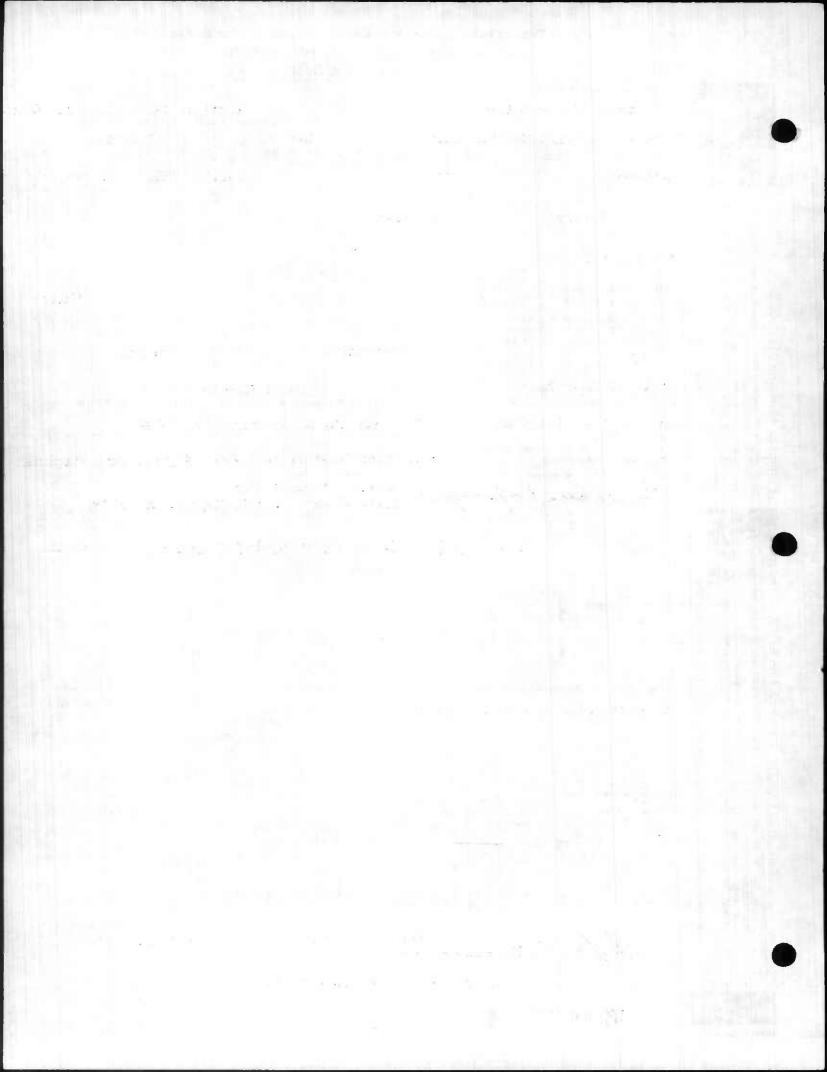
Walter K. Naumann, M.D., PO Box 247, Accident MD 21520 31. Data filed (Month, Day, Year)

State Registrar

APR 0 9 1999







State of Maryland / Department of Health and Mental Hygiene

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| | | 1 | | 1 |

WILLIAM B. SMITH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 2, 1999 APRIL 0141 AM William Barkley Smith /Medical 4a Fecility Name (If not institution, give street and number)
MEMORIAL HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY If Under 1 Yeer 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1XM 2□ F Yrs. 236-06-8199 28 Director Feb. 14,1971 West Virginia Usual Residenca of Decedent with the Manyland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow ad cal Exampler must be notified at 1 ☐ Yes 2 No Director Mineral 1 Keyser 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Rt. 1 26726 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🗷 No 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after thygiena. 1 ☐ Never Merried 2 Married 21215-0020 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed The Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Laborer's Union Laborer Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic avery Frank W. Smith. Jr. Betty M. White 19e. Informant's Neme/Reletionship (Type, Print) Parents 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Frank W. Smith, Jr. Rt.1, Box 226-A Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete April 6 1999 permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, WV 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility 0 Rotruck-Smith Funeral Home Drian 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each fine. Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner iclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) physician s the buriel Box 68760, the death certificate be Physician/Medical that initieted events rasulting in daeth) Lest Due to (or es a consequenca of): 98 USB signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 20 No 3 Probably 4 Unknown Records. à The law requires 24b. Wera autopsy findings availabla prior to completion of cause of deeth? should should 24e. Wes an autopsy performed? Completed page 2 of Vital Physician: Be 25. Wes case referred to medical 26. Placa of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XT Yes 2 No Certification: To 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of fnjury Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 1 Natural 5 Pending invastigation 28el Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 2 0106 2 No death. 1 Yes 2 Accident river in auto occurs 24 hours after deat Funeral Director: 281. Location (Street and Number or Rural Route Number City of Town, State) 3 ☐ Suicide 6 Could not be determined 4 Homicida 6 Storthe filled in 27 Va Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

**Wedical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner steted. Medical 29a. Certifie completely one) within 2 \$ 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signally O.C.M.E APRIL 2, 1999 ms ss of person who completed cause of death (ftem 23a) (Type, Print) 6

DHMH 16 Rev 6/95

State

Registrar

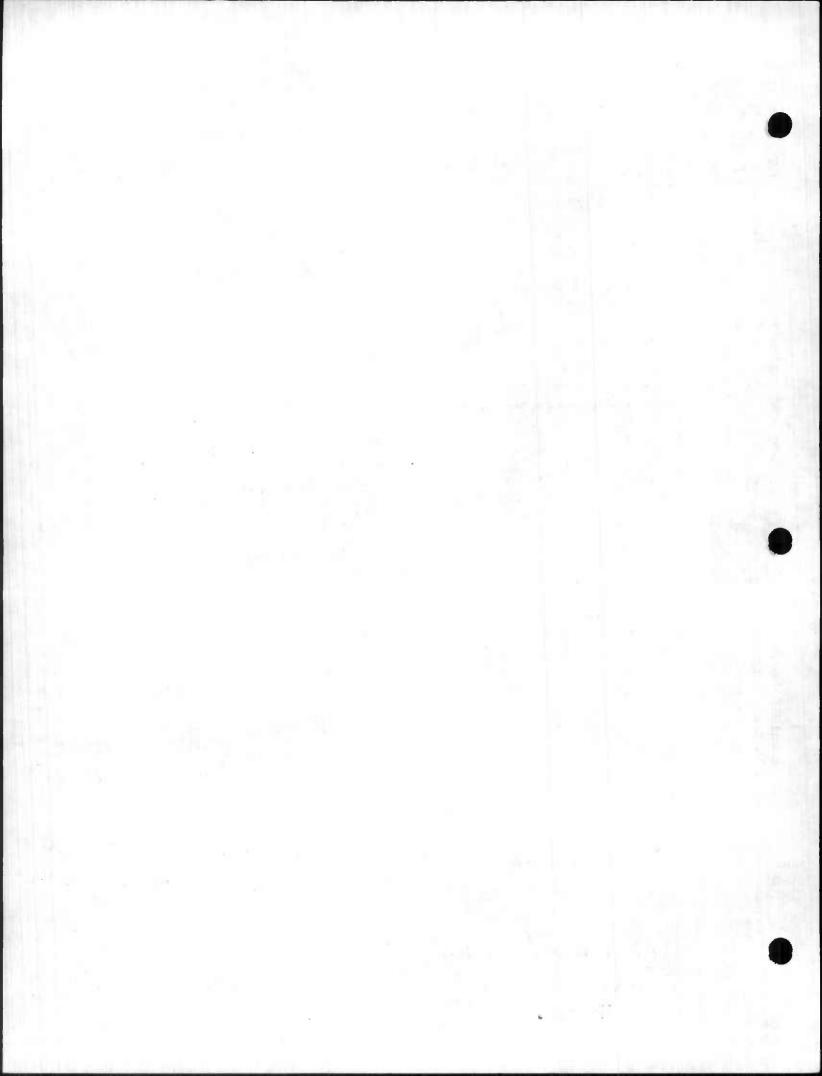
31. Dete filed (Month

Day, Year)

APR 09

32. Registratr's Signature

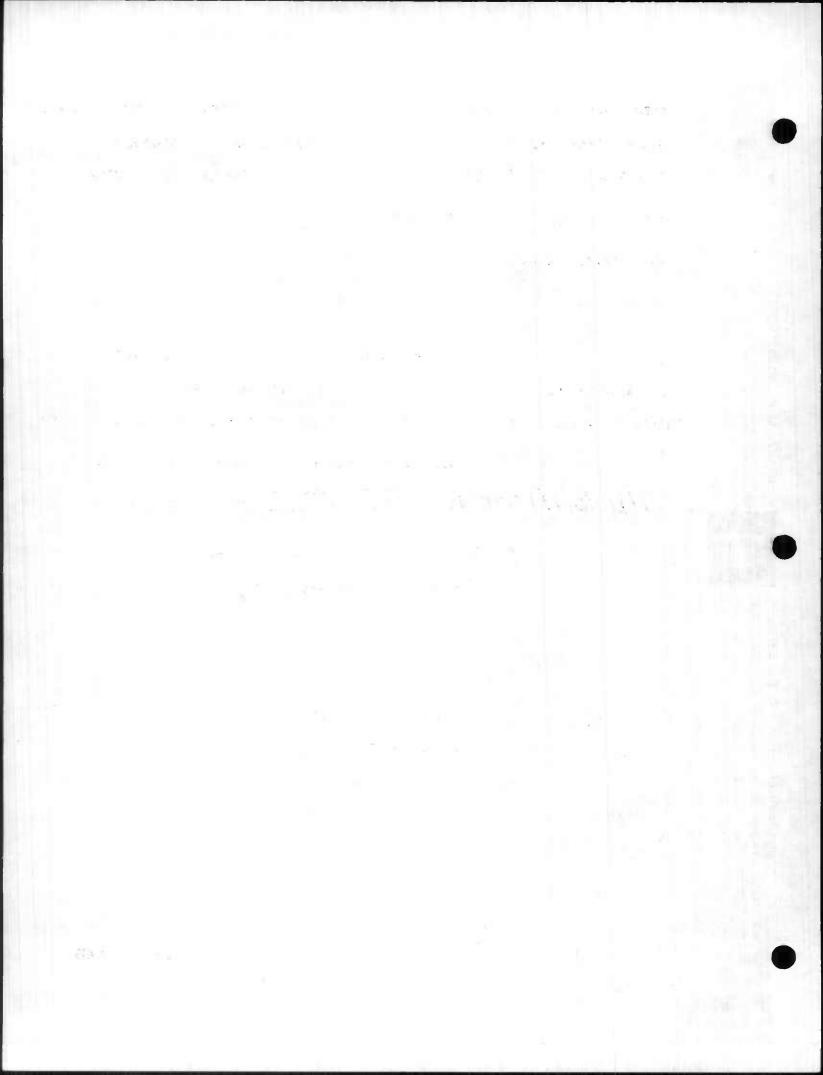
111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 1999 APRIL AURORE THEODORA ST. AMAND 2:50 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year if Under 24 Hrs. Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 KF Yrs Director CANADA 011 50 3898 98 with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Manical Examiner must be northed at 1 Yes 2 □ No FROSTBURG MARYLAND ALLEGANY Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 100 HONEYSUCKLE LANE 21532 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item only injury or other treumetic event, the Westerl Exercises and 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Merried 2 Married 1☐ Yes 21 No Specify: Specify à 3 ₩idowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be EMMA BEAUCHESNE ADELARDE GAGNON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PHILIP ST. AMAND / SON 15405 HIHG POINT COURT, SW, CUMBERLAND, MD 21502 Baltimore, 20a. Method of Disposition

Buriel 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) 4/9/99 JOSEPH CEMETERY AMESBURY, MA 22. Name and Address of Fecility SOWERS FUNERAL HOME, P.A. 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical **Examiner** Examiner physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): ettending physician Physician/Medical Due to (or as e consequence of) 1 Se esn . Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown Division of Vital Records, à 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? or Attending Physician: 25. Wes case referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1- Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation TO Natural s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours e 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 3 D2124 APRIL 6 1999 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Frostlourg Rlaza Frostburg MD Z153Z mus 32. Registra's Signetur State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 nth Physician THIBODE DAUL /Medicai 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** MEADOW GREEN ESTHINSTER f Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 10 M 2□ F 302-07-431 80 Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? BOX 0. items 23a 12. Was Decedent Ever in U,S. Amged Forces? 1 M Yes 2 □ No If Yes, Give Year or Detes: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 2 Married 1 Never Married 6 1□ Yes 2□ No 3 Widowed 4 Divorced White "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiena. Important: if Item 27 is merited other than "na eny Injury or other traumatic even." ing most of working Elementery/Secondary (0-12) College (1-4or 5+) ELECTRICAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be 741BODO Lo ensal Len 19a. Intormant's Name/Relationship (19th Print) 19b_Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 20b. Placa of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signature of Funeral Service Cid 22. Name and Address of Fecility Fuen 23a. Pert1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one ceuse on each line. Do not enter the mode of dying, such as cardiac or respirato **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence ot) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be datached for use as the buna Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No þ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? within 24 hours after death. To the Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only Other: 4 Nursing Home 10 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Desidence 6 □Other (Specify) 27. Manner Certification: 28b. Time of 28d. Describe how injury occurred 1 Watural

28c. tnjury et Work?

5 Pending investigation 1 Yes 2 Accident 3 Suicide

6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30 Name nd address of person who completed cause washington Rd. ames

State Registrar 31. Date filed (Month, Day, Year) APR 0 5 1999

32. Registrar's Signat re

death with the Maryland

filed within 72 hours after

The law requires that the death certificate be executed

or Attending Physician:

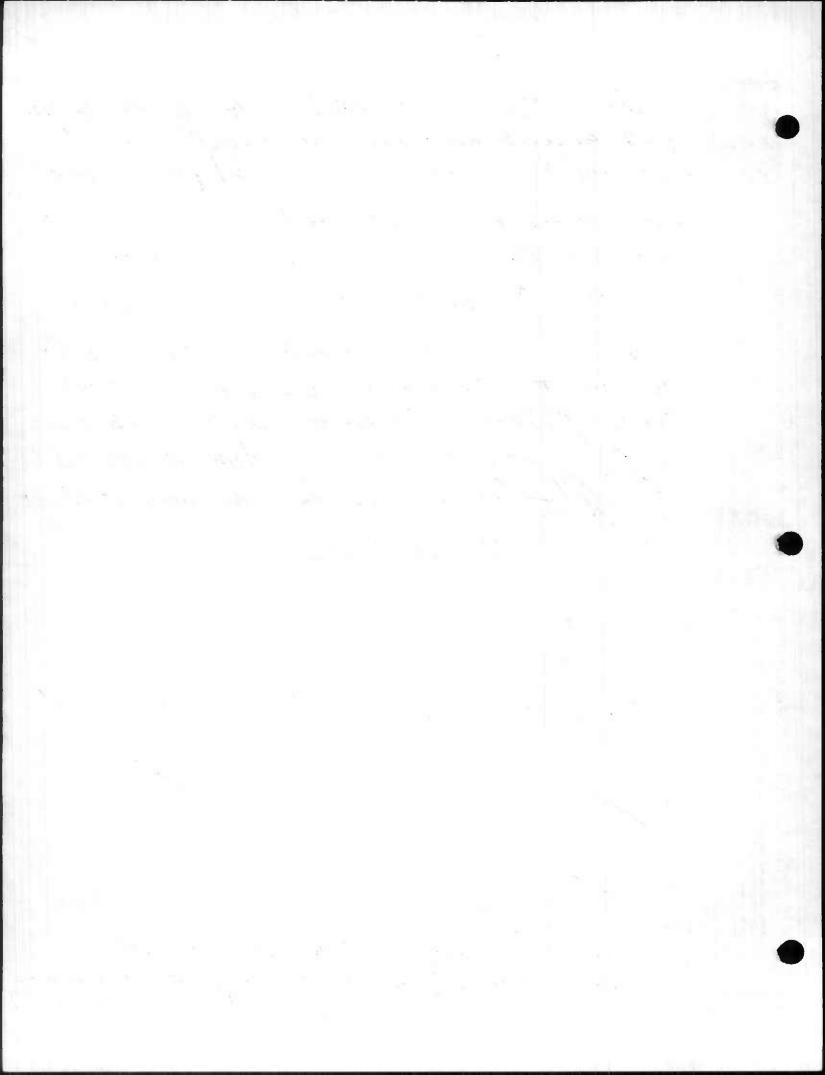
the

in by t

Medical

Division of Vital Records, P.O. Box 68760.

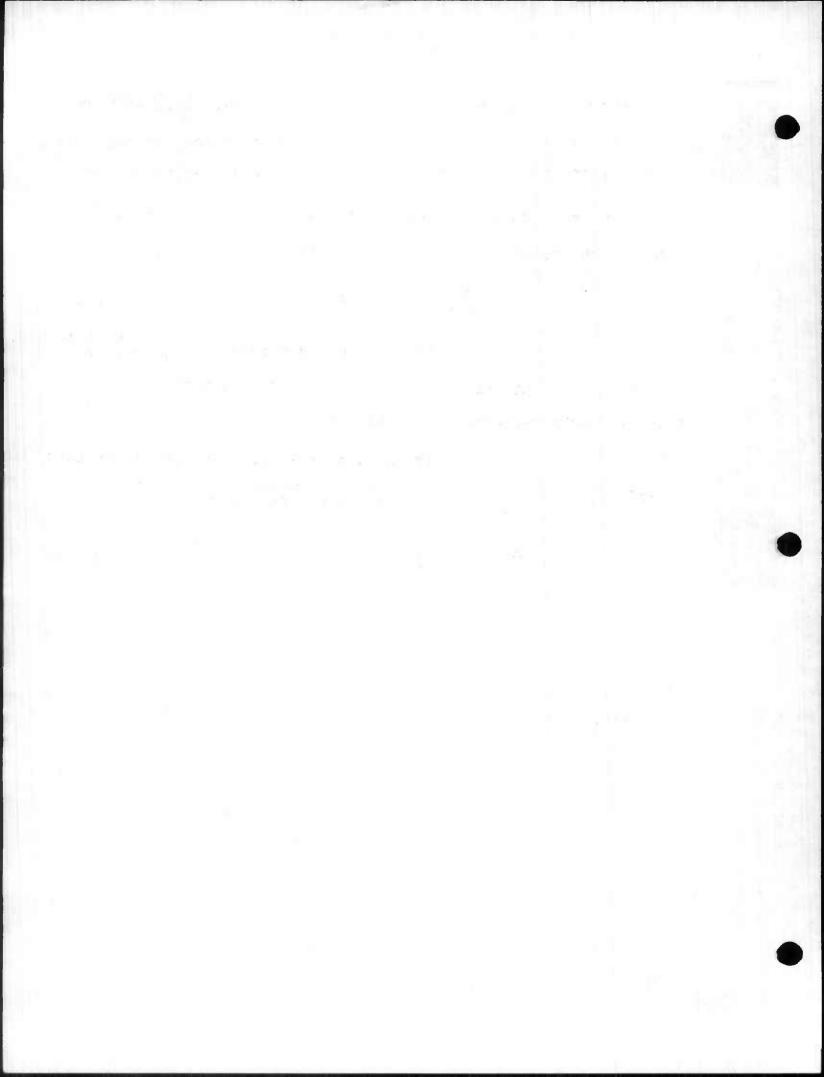
Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** APRIL 10°,1999 23:10 HERMAN GREEN THOMPSON /Medicai 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death Examiner 1926 TAYLOR AVENUE PRINCE GEORGE FORT WASHINGTON | Months | Deys | Hours | Min. | A PRIL 25,1927 | TENNESSEE 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funerai** ₩ 20 F 72 Yrs. Director 410-40-1388 Usual Residenca of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show MARYLAND PRINCE GEORGE

10e. Street and Number 1 Yes 2 No FORT WASHINGTON 10f. Zip Code 10g. Citizen of What Country? death with 20744 1926 TAYLOR AVENUE U.S.A. Home 2 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedenf of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, Whita, afc. 11. Marital Stafus r than "natural", or iten filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No RET) If Yes, Giva (RET) Yaar or Detes: USAF 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 18e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Spacify only highest greda completed) l Hygiene. HOUSING & URBAN DEV. Elementery/Secondery (0-12) College (1-4or 5+) DIRECTOR OF COMPUTERS 12 U.S.GOVT.(RET) traumetic event, Baltimore, Maryland 17. Fathar's Neme (First, Middle, Last) Peges 1 and 2 should be fill ment of Haalth and Mental H tant: If Item 27 is marked oth 18. Mother's Neme (First, Middle, Meiden Sumema) Be HERMAN GREEN THOMPSON, SR. MATTIE HACKNEY 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Haalth a: If item 27 is EDNA E. THOMPSON-SPOUSE SAME AS #10 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 4-14-99 WALDORF, MARYLAND TRINITY MEM.GARDENS 21. Signeture of Funerel Servica Licansee 22. Name end Address of Fecility RAYMOND FUNERAL SERVICE, P.A. Mic 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. LA PLATA, MARYLAND 20646 Approximate Intervel Betw Onsat and Deeth **Physician** Immediate Cause (Final lancred: Mo disease or condition resulting in deeth) Examiner The law requires that the death certificets be axecuted bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated evenfs resulting in deeth) Lest end Due to (or as e consequenca of): P.O. Box 68760. ettanding physiclan Physician/Medical for use as the Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 2 No 3 Probably 4 Unknown 1 Yes -uno Cancer Division of Vital Records, þ dementos, alzheiners type 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Deen certificata Attending Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this filled in by the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred Neturel 5 Pending s eftar death. 1 Yes 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, streef, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 6 To the Hospital o within 24 hours of To the Funeral DI completely filled is 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piaca, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner steted. 29a. Certifier Medicai (Check only one) 29c. License number M. Ll. 14.4 29b. Signefure end title of certifier 29d. Date signed (Month, Dey, Year) ret aun 4301062644 30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print) , AAFB MD 20762 10 to W. Per noter Rd Kenneth L. Albert, MI) 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) APR 12 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 13202

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| Physician /Medical | K e | athryn Metz | Tyler | | | | | | | April | | 99 | 8:00 an |
| /Medical Examiner | 40 5 | acility Nama (If not institution, g | riva street and numb | er) | | | 4 | b. City, Tov | vn, or Lo | cation of Death | | ounty of Deat | h |
| LAGITITIO | | ll4 Laurel Aven | lile | | | | | Chev | erly | | Pri | nce G | eorge's |
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| ra rai | 31 | ll4 Laurel Aven | | | | | 2078 | | | | _ | S.A. | |
| r items 23a Iron must Funeral | 11. N | Marital Status | 12. Was Deceda | as? | S. 13. V | Vas Deced Yas, spec | dant of Hi cify Cuba | ispanic Oriç ın, Maxican | gln? (Spe , Puarto | ecify Yas or No Rican, atc.) | - 14 | Race - Ama Black, White | |
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| ner than "natural", it, the Medical Ex Completed by | | 15. Decedent's (Specify only highest of | Education | | 16a. Deced (Giva I lifa. D | ant's Usua | al Occupa | ation | of worki | ina | 16b. Kind | of Businass/ | Industry |
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| then the M | | 12 | 34 (1 | | Но | mema | ker | | | | Own | Home | |
| d othe event, Be C | 17. F | athar's Nama (First, Middla, Las | st) | | | | | 18. Motha | r's Nama | (First, Middla, | Maidan Su | mama) | |
| | | Leo Metz | | | | | | Ma | rior | ie Ohl | man | | |
| mer T | | . Informant's Name/Ralationship | (Type, Print) | | 19b. Meilin | g Addrass | (Street | | | al Routa Numbe | | own, State, 2 | (ip Coda) |
| | | dward W. Tyler | | | | | | | | everly, | | | |
| tem 27 is merke other treumstic To | | Method of Disposition | - nusbanc | | | | | | , 611 | Data Data | - | tion - City or | 20785 |
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| d'a | | 4 ☐ Donation 5 ☐ Other (Spec | | | land Vo | eteran | is Cer | metery | 04 | 4/13/99 | Chel | tenham | , Marylar |
| Important: If Item 27 is any injury or other tre once. | 21. 5 | Signatura of Funaral Sarvice Lic | ensee | | | | | ss of Facilit | | D 4 | | | |
| E | | 000,00 | 11-01 | 2 | | | | | | ne, P.A. | | 17 - 10 | 20701 |
| | 239 | Part1 Enter the disease or co | molications that can | sad the death | Do not ente | ar the mod | all LI | more A | cardiac o | ie, Hyat | rast | Lie, Mi | 20781 Approximete |
| | | Part1. Entar tha disaasa, or co shock, or haart failura. List on | ly one ceuse on aac | h lina. | | | | | | | | | Intarval Between Onsat and Death |
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| miner | disa | asa or condition | a | VICE | 7/12 | (| 17/ | 200 | - | | | | MUN |
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| g physician and as the bunal-transit | Seq | uantially list conditions, ly, laading to immediate se. Entar Undarlying | | Dua to (or | as a consaq | uance of): | | | | | | | |
| unial unial | Caus | se. Entar Undarlying | | | | | | | | | | | |
| physician and is the burial-tra edical Exar | that | initieted avents | G | Dua to (or | as a consequ | uance of): | | | | | | | |
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| detached for undetached Post | II. Other significant conditions | anatribution to deat | h hut not social | tion to the un | adach dan e | auaa ahu | on In Doct 6 | | 22h Did | toheooo uu | o contribute | to the cause of de |
| ched ched | ranti | II. Other significant conditions | Continuating to deal | 11 DUI 110(18501 | iting in that un | idanying c | ausa yiv | ann ran i | | | | | |
| | | - | | | | | | | | 10 | Yes 2 | NO 3LIPI | robably 4 Unk |
| detac | | | | | | | | | | - | | 24h | Wara autopsy findin |
| bed by | - | | | | | | | | | O40 10400 | | 270. | rraia autopay iirium |
| bed by | - | | | | | | | | | 24a. Was perfo | an autopsy rmed? | | available prior to |
| bed by | - | | | | | | | | | | | | available prior to completion of cause of deeth? |
| hes been signe ge 2 should be d mpleted by | - | | _ | | | | | | | | rmed? | | complation of cause |
| ate hes been signer page 2 should be d | 25. V | Was case referred to medical | | | | | | 26. Place | of Deat | perfo | rmed? | | complation of cause of deeth? |
| certificate has been signer rector, page 2 should be d Be Completed by | 25. V | axaminar? | Hospital: 1 🗆 Inc | vationt 200 | -B/Outpatien | t 3□ D | Oth. | or: | | perfo | ormed? Yes 2≅ ona) | No | complation of cause of deeth? |
| this certificate has been signer ral director, page 2 should be d : To Be Completed by | 25. V | Was case referred to medical axaminar? I ☐ Yes 2 ☐ No Manner of Deeth | 28a. Data of | Injury | ER/Outpatien | | JA | ar: 4□ Nu | rsing Ho | perfo | Yes 2 🗗 ona) denca 6 [| No Othar (Spe | complation of cause of deeth? |
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| this certificate has been signer ral director, page 2 should be d : To Be Completed by | 25. V | axaminar? 1 | 28a. Data of (Month, | Injury Day Year) | 28b. Tima of Injury | M 2 | 28c. Injun Worl | ar: 4□ Nu | rsing Ho | h (Chack only o | Yes 2 Fona) denca 6 [how Injury of | No Othar (Special Control of Cont | completion of cause of deeth? |
| this certificate has been signer ral director, page 2 should be d : To Be Completed by | 25. V | axaminar? 1 | 28a. Data of (Month, ion 28e. Piece of | Injury | 28b. Tima of Injury | M 2 | 28c. Injun Worl | ar: 4□ Nu yat k? | rsing Ho | h (Chack only o | Yes 2 (a) Ona) denca 6 (a) how injury of | No Othar (Special Control of Cont | complation of cause of deeth? |
| Orector: After this certificate has been signed in by the funeral director, page 2 should be described by trification: To Be Completed by | 25. V 8 1 1 27. M | axaminar? 1 Yes 2 No Wanner of Deeth Weturel 5 Panding 2 Accident invastigati 3 Suicida 6 Could not | 28a. Data of (Month, ion 28e. Piece of | Injury Day Year) Injury - At hor | 28b. Tima of Injury | M 2 | 28c. Injun Worl | ar: 4□ Nu yat k? | rsing Ho | h (Chack only of the Chack on the C | Yes 2 (a) Ona) denca 6 (a) how injury of | No Othar (Special Control of Cont | completion of cause of deeth? |
| Orector: After this certificate has been signed in by the funeral director, page 2 should be described by trification: To Be Completed by | 25. V 8 1 1 27. M | axaminar? 1 Yes 2 No Manner of Deeth 1 PNeturel 5 Panding invastigati 3 Suicida 4 Homicida 6 Could not determine Cartiflar 1 Certifying F | 28a. Data of (Month, see and of the | Injury Day Year) Injury - At hore, afc. (Spacify) | 28b. Tima of Injury ma, farm, stra | M aat, factor | 28c. Injun World 1 U | ar: 4 Nu yat k? Yas 2 34 | nsing Ho | h (Chack only of the Chack only or Total | Yes 2 ona) denca 6 (how Injury of Streat and wn, Stata) | Othar (Special Control of Polymer of Rumber of Rumber and mennar as | complettion of cause of deeth? 1 Yas 2 No city) ural Routa Number, |
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| Funeral Director: After this certificate hes been signe ately filled in by the funeral director, page 2 should be didical Certification: To Be Completed by | 25. V 8 1 1 27. M 1 2 29a. 29b. | axaminar? 1 Yes 2 No Wanner of Deeth Manner of Deeth Specification Cartifiar (Check only one) Signatura and title of certifier | 28a. Data of (Month). be 28e. Plece of building Physician: To the beaminer: On the basis | Injury Day Year) Injury - At hore, atc. (Spacify) est of my knows of axamination stated. | ma, farm, stra | M aat, factor | 28c. Injun Word 1 y, offica at the tim, in my of | ar: 4 Nu Nu y at k? Yas 2 4 na, data anpinion, daa a number 6 9 3 | d place, | h (Chack only of the state of t | Yes 2 Pona) denca 6 [how Injury of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of thick of thick of the thick of thic | No Other (Specocurred Number or Rund mennar as lace, and due signed (Monte) | completion of cause of deeth? I Yas 2 No city) ural Routa Number, stated. to the cause(s) h, Day, Year) |

Kalhuyu Tyle

888 2 5 5 5 A

| | | | Certificate of Death | | () | 9 13203 |
|-------------------|---|------------------|--|----------------------------------|-------------------|---|
| | | | 1. Decedant's Nama (First, Middle, Last) | 2. Data of Dear | | 3. Time of Death |
| | Physic /Medi | | MAMIE EdNA / hompson | april | | 7:30 PM |
| | Examii | | 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or L. | | 4c. County o | |
| | | | Mariner Health Care Clinto 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. | _ | PriNC | 9. Birthplaca (Stata or Foreign |
| п | Funeral Director | r | 577-20-0788 1 M 2XF 95 Yrs. Months Days Hours Min. | 8. Data of Birth (Month, Day) | -03 | S. Carolina |
| | pu » | | Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location | | | |
| | Maryle f eho | 20 | MD Prince Georges District Heights | | | 10d. Inside City Limits 1 ✓ Yas 2 □ No |
| | r 28a | irect | 1 10e Street and Number | 1 | 0g. Citizan of W | hat Country? |
| | 23a c | Funeral Director | 6103 Cabot Street 20747 | | USI | 4 |
| | hems hems | une | 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 1 □ Navar Marriad 2 □ Marriad 1 □ Yas 2 □ No Specify: 11. Was Decedant of Hispanic Origin? (Sp. If Yas, specify Cuban, Maxican, Puario II □ Yas, Give | ecify Yas or No- Rican, atc.) | | - Amarican Indian, c, Whita, atc. |
| 020 | rurs efter death with the Maryler all, or items 23a or 28a-f show Examiner must be notified at | by | 1 Navar Marriad 2 Married 1 Yas 2 No If Yas 2 No Specify: Yaar or Datas: | | Specify: | Black. |
| 5-0020 | n 72 hours efter death with the Maryland "netural", or items 23s or 28s-f show officel Examiner mast be notified at | Completed | 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of work | ina | 16b. Kind of Bus | sinass/Industry |
| 2121 | within iena. than " | mple | (Specify only highest grada complated) (Give kind of work dona during most of work life. DO NOT use retired) All Maintenance | | Fodo | ral Government |
| | Hygie off, II | Be Co | 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama | a (First, Middla, I | | |
| /lar | should be filed within and Mentel Hygiena. I marked other than umatic event, the Mentel and the | To B | Clarence Jolly Atla | nta A | Lock | hart |
| Maryland | 2000 | ľ | 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Run | al Route Number | City or Town, S | State, Zip Code) 2072 |
| 11 | 1 and Health arm 27 other tr | | James J. Thompson Sr. 9/3 Cyprus Po 20a. Method of Disposition (Name of | Data Data | 20c. Location - C | , Mitchellville M |
| E O | Pages ant of nt: # it | | 1 Burial 2 Cramation 3 Ramoval from Stata cemetery, crematory or other place) 1 Color (Specify) 1 Ramoval from Stata | 4-9-99 | Suffe | and MD |
| Baltimore, | Departm Departm Importa any inju | | 21. Signature of Funeral Service Licenside 22. Nama and Addrass of Facility | STRICK | KLAND | Funeral Sus |
| m | Den Pen | = | Obiel Streffer 6500 Allento | un Rd, | CAMOS | OriNGS, MO2074 |
| | | | 23a Annual Private the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac about or heart failure. List only one cause on each line. | or raspiratory arr | est, | Approximate tntarvai Between Onset and Death |
| | Physician /Medical | | Immediata Causa (Finai | | | ZWKS |
| | Examiner | | disassa or condition resulting in death) Due to (or as a consequence of): | | | ZWRS |
| | po ti | Examiner | b. — | | | |
| Ć, | iceta be axecuted physician and s the buriel-transit | Exan | Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or injury c. | | | |
| 68760, | ysicia he bur | edical | Cause (Disaasa or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): | | | |
| | | | d. | | | |
| Вох | law requires that the deeth certifies been signed by the ettending as been signed by the ettending 2 should be detached for use et | Physician/M | | | | |
| P.O. | that the de ed by the e detached t | hysi | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did to | 1 | tribute to the cause of death? 3 Probably 4 Unknown |
| | es the igned be de | by F | Congestive Heart Failure | | | |
| ord | v require been si | eted | Anemia | 24a. Was a perform | | 24b. Wara autopsy findings available prior to completion of cause |
| Rec | 0 - 5 | Completed | | | | of daath? |
| tal | certificate h | Be Co | 25. Was casa rafarred to medical 26. Placa of Death | 1 Ye | | 1 Yaa 2 No |
| of Vital Records, | 5 00 | To B | axaminar? | ma 5□ Rasida | | r (Specify) |
| | ing Pt | | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury at Work? 28c. Injury at Work? | 28d. Dascribe ho | | |
| Division | Attend death ctor: / | ficat | Accidant invastigation M 1 Yas 2 No 3 Suicida Suicid | 28f. Location (Si | reet and Numbe | er or Rural Route Number, |
| 2 | s effer i Dire | Certification: | 4 Homicide determined determined building, atc. (Specify) | City or Town | n, State) | · · · · · · · · · · · · · · · · · · · |
| | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral | edicai (| 29a. Cartifiar (Check only Check only C | and dua to tha cr | ausa(s) and man | inar es stated. |
| | within 24 | Med | one) and mannar stated. 29b. Signatura and titla of cartifiar 29c, Licansa number | | | (Month, Day, Year) |
| | | | > Sam + 18 11/ 1024271 | 1 | 4-6 | -901 |
| | 161 | | 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) | | , , | |
| (| 9 | | P-SAM Tellawi 7700 Old Branch Ave E | 3-102,0 | lenton | MD 20735 |
| | Sta Registr | | 31. Data filed (Month, Day, Year) APR 0 6 1999 32. Pegistrar's Signatura | • | | |

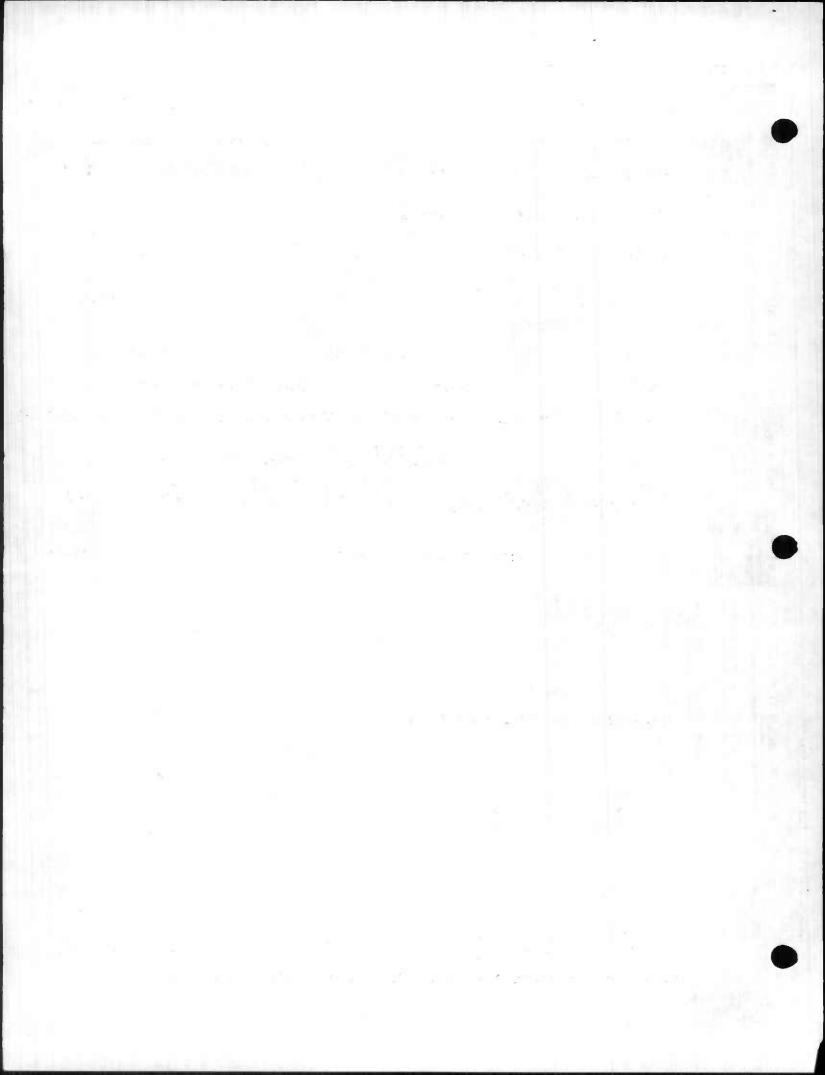
10% . **\$** 2 de

DHMH 16 Rav 6/95

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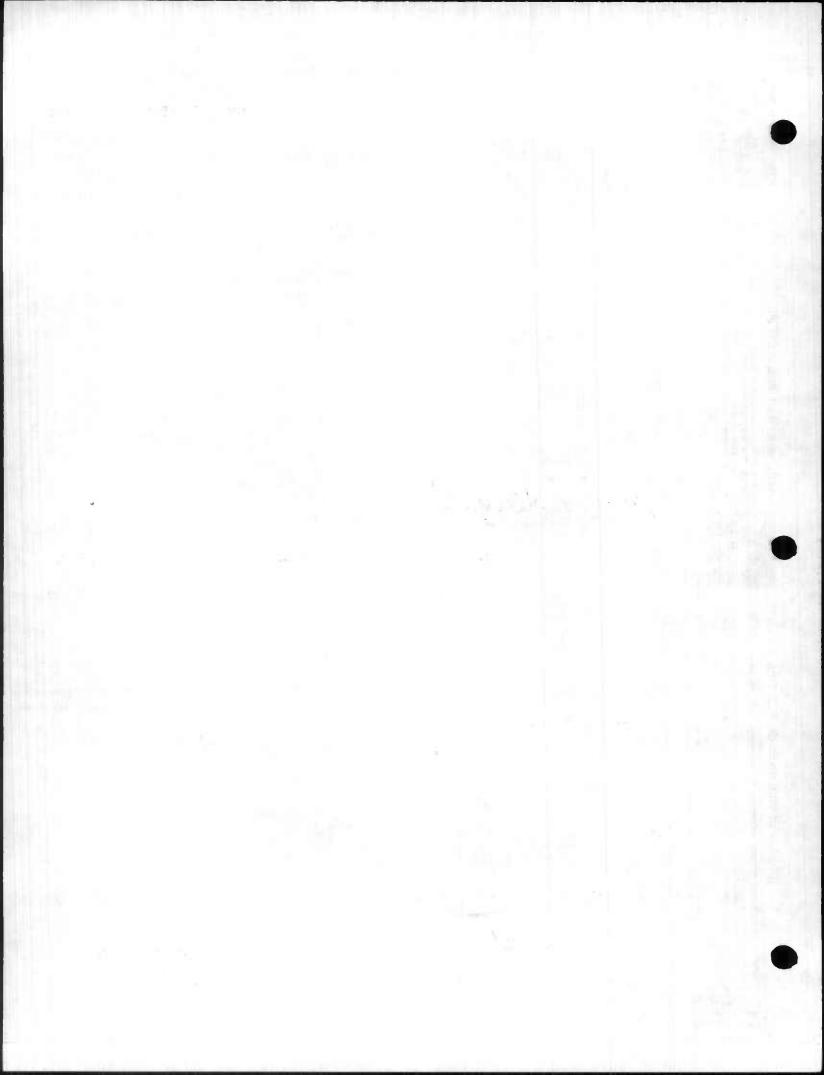
Turley

Mary



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Marguerite Valentine Louise APRIL 7, 1999 1250 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Sacred Heart Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Deys Hours Mb 220-10-1790 80 Yrs. **Director** Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Medical Evant is a martie to notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes �☐ No WV Mineral Ridgeley Directo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 26753 USA Route 1 Box 171 Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Retired Employee McCrory Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Flossie (Wellen) Joseph E. Myers 19a. Informant's Name/Relationship (Type, Print)
Alan Paxton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 Wildcat Hollow; Cumberland MD 21502 friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 XBurial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gard4/10/ LaVale, MD 21. Signature of Funerel Service Licensee 2Scarper Fruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that obsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on unch line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HYPOTENSIVE SMOCK 8 Hrs Examiner Due to (or as a consequence of): Examiner 8 HRS ANEMIA ettanding physicien end for use es tha buriel-transit certificate be axecuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Physician/Medicai that Due to (or as a consequence of): 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DEEP VEIN THROMBOSIS EXTENSIVE Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed DEPRESSION page 2 s certificate has 1 Yes 2 No 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 1 Inpatient 10 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending after daath. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital 29a. Certifier 1 [Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 hor To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 23334-2 APRIL 87 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 JOHNSON HTS MED BLOG, CHMBERLAND, MD M-D 205 MU . SHAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 2 1999 Registrar



| LINDA WILSON | | State of Marylar | | artment of H tificate of | | d Mental Hy | 0.0 | 1 | 3206 | | | |
|--|---|--|------------------|--|--|---------------------|---------------------------------|-----------------------|------------------------------|--|--|--|
| | Decedent's Nama (First, Middla, La | ist) | 001 | imouto or | Douth | 2. Date of D | Reg. No. | | 3. Time of Death | | | |
| Physician | Linda Lee | Wilson | | | | Month | Day | Year | 11:00P.M. | | | |
| /Medical Examiner | 4a Facility Nama (If not institution, give | ra street and number) | | | 4b. City, Town, | or Location of Dea | th 4c. County | of Death | | | | |
| Examiner | LANHAM SEVERN ROA | D & WINGATE DE | RIVE | | BOW | IE | PRINCE GEORGES | | | | | |
| Funeral | 5. Social Security Number 6. S | | last birthday) | If Under 1 Year Months Days | If Under 24 I Hours A | Hrs. 8. Data of B | irth | ace (Stata or Foreign | | | | |
| Director | 213-34-0003 | 1□ M 2\(\textbf{X}\)F 49 | 9 Yrs. | Months Days | 110013 | yland | | | | | | |
| D | Usual Rasidance of Decedant 10a. Stata 10b. County | 10c Ci | ty, Town or Lo | cation | | | | 10 | Od. Inside City Limits | | | |
| Anyth sed as | Maryland Prince | | | | | | 1 ☐ Yes 2 💢 | | | | | |
| or 28e-f a | 10a. Street and Number | George S | MITCHE | 11ville | | | 10g. Citizen of What Country? | | | | | |
| The or | 11502 Lottsford | Road | | 207 | 21 | | U.S.A. | | | | | |
| Of the death with the Maryla of thems 23a or 28a-f sho niner must be notified at Furneral Director | 11. Marital Status | 12. Was Decedant Evar in U | J,S. 13. V | Was Decedent of H | lispanic Origin'i | (Specify Yas or N | No- 14. Race - American Indian, | | | | | |
| or lite | | Armed Forces? 1 ☐ Yas 2 ☒ No | | | s, specify Cuban, Mexican, Puarto Rican, atc.) | | | | | | | |
| 5-0020 72 hours after metural*, or its disal Examina | | If Yas, Giva Yaar or Datas: | | I□ Yas 2∏ No | Specify: | | Specify | te | | | | |
| Maryland 21215-0020 2.2 should be flied within 72 hours at thand Mental Hygiere. 7 is marked other than "natural", or treumatic event, the Medical Exam To Be Completed by F | 15. Decedent's E- (Specify only highast gra | | 16a. Deced | lent's Usual Occup kind of work dona OO NOT use retire | oation during most of | working | 16b. Kind of Bu | siness/Ind | ustry | | | |
| TO PER PER PER PER PER PER PER PER PER PER | Elementery/Secondery (0-12) | College (1-4or 5+) | lifa. E | | d) | | W G D | | · · | | | |
| Co Hygie | 17. Fathar's Nama (First, Middla, Last | 1 | | Clerk | 18 Mother's | Nama (First, Middl | U.S. Po | | rice | | | |
| d be ill | Russell Carter, | | | | | | ,, | | | | | |
| should be and Mental marked or marked ev | 19a. Informant's Name/Relationship (| | 19b. Mellin | na Addrass (Street | Amy | Lee We | | Stata. Zio | Code) | | | |
| 6586 | Milo Lee Wilson. | | | | | e, Chesa | | | | | | |
| O - 1 1 1 | 20a. Mathod of Disposition | 206. [| Place of Dispos | sition (Nama of natory or other pla- | | Data | 20c. Location - | | | | | |
| Pages narri of mt. if the ary or o | 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | JHamoval from Stata | | oln Ceme | | 04/10/99 | Brentwo | od. M | Maryland | | | |
| Parity Pa | 21. Signature of Funaral Sarviol Licer | | 22 | Nama and Addra | ss of Facility | | | ou, i | ary raine | | | |
| 00 88558 | Henry S.c | to 0 | | | | ome, P.A enue, Hya | | o MD | 20781 | | | |
| | 23a. Part1. Entar the diseasa, or com shock, or heart faitura. List only | plications that caused the deal | | | | | | | Approximate Intervel Between | | | |
| Physician | Shoot, of Hadit layout. List only | One couse on agon mig. | | | | Onset and Death | | | | | | |
| /Medical Examiner | Immediata Causa (Final disaasa or condition | MUUTIPLE | TOW | miss | | | | | | | | |
| | rasulting in death) | Due to (| | | | | | | | | | |
| osecuted n and isl-transit | | b | | | | | | | | | | |
| 8760, sate be executed shysician and the bunal-transit dical Examin | Sequentially list conditions, if any, leading to immediate | Dua to (d | or as a conseq | uence of): | | | | | | | | |
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| ificate globys as the edic | rasulting in death) Last | Dua 10 (0 | or as a consequ | uence of): | | | | 1 | | | | |
| P.O. BOX 68760, nat the death certificate be executed by the attending physician and letached for use as the bunal-transit Physician/Medical Examis | | d | | | | | | | | | | |
| | Part II. Other significant conditions of | 23b. Did tobacco use contributs to the cause of deal | | | | | | | | | | |
| ecords, P.O. I law requires that the de as been signed by the a 2 should be deteched in pleted by Physic | | | | | ably 4 Unknown | | | | | | | |
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| law range of the control of the cont | | | | | | | | of d | npletion of cause seath? | | | |
| = F # 8 0 | | | | | | 12 | Yes 2□ No | 45 | Yes 2□ No | | | |
| Of VITAI REC Physician: The law ribis certificate has trail director, page 2 a | 25. Was case ratarred to medical axaminar? | Mossitel: | | Ort | 200 | Death (Check only | | | | | | |
| T SHE F | 1 X Yas 2 No 27, Mennar of Death | | ER/Outpatien | | 4 LI NUISI | g Homa 5 ☐ Ras | | | | | | |
| After fune | 1 □Natural 5 □ Panding | 28a. Data of Injury (Month, Day Year) | Injury | PM 1□ | rk? Yas Zi No | 0.00 | how injury occur | | Burwith can | | | |
| DIVISION I or Attanding after death. Diractor: After d in by the fune ertification | 3 Suicide 6 Could not b | e 200 Pleas of Injury At h | 0 | | 140 2 110 | 28f. Location | (Street and Numb | | | | | |
| - X2+c E | 4 Homicide | building, atc. (Specil | (y) | | | City or To | own, Stata) | | WA | | | |
| The Hospital of the European State of the Eu | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner es stated. | | | | | | | | | | | |
| The Hospitan 24 hours Funer Funer Funer Funer Wedical | (Check only one) 2 Medical Exam | niner: On the basis of axamina and mannar stated. | ition and/or inv | estigation, in my o | opinion, death o | ccurred at the time | , date end place, | and due to | the cause(s) | | | |
| 2000 3 | 29b. Signatura and titla of certifiar | . 1/ 0.0 | | 29c. Licens | se number | | 29d. Date signe | d (Month, L | Day, Year) | | | |
| | Maynte In | ighil | | 0.0 | .M.E. | | APRIL 3 | , 1999 | | | | |
| (20) | 30. Nama and addrass of person who | | n 23a) (Type, I | · | | | | | | | | |
| | MARGONAND A.K | 0164 412 | | III Penn | Street | , Baltim | ore, Mar | yland | 21201 | | | |

Registrar

APR 0 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Tima of Death De Yeer **Physician** WATKINS MAGGIL 1555 L 99 /Medical County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) **Examiner** 6. COUNI HUSPETAI CHEVITL 6. If Undar 24 Hrs. 9. Birthpleca (State or Foreign Washington, D.C. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Undar 1 Year 5. Social Security Number **Funeral** 10 M 20 F Months Deys Hours Min 58 578-54-5442 Yrs. **Director** Usual Residence of Decedent the Marylend r 28a-f show 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Landover Prince George's Mary land 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pegas 1 end 2 should be filed within 72 hours efter death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural, or items 23s or 2 any Injury or other treumetic event, the Medical Examiner must be in page. 20785 U.S.A. 7360 Landover Road Apt. #C Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 Never Married 20 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Laundry Aide Domestic 12th grade 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fathar's Neme (First, Middle, Last) Ida Mae Campbell Tommie S. Gore 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
6701 Vermont Court Landover, Maryland 20785 19a. Intormant's Name/Ralationship (Type, Print) Miss Denise Watkins (Daughter) 20b. Place of Disposition (Name of cemetary, cremetory or other place)
National Harmony Memorial Park 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Deurial 2 Cremation 3 Ramovel from Stete 4/12/99 Landover, Maryland 4 ☐ Donelion 5 ☐ Other (Specify) 22. Name end Address ot Fecility Rollins Funeral Home, Inc. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feitura. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical **Examiner** Examiner attending physicien end for use es the buriel-transit thet the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical Due to (or as e consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 Yes 2 No 3 Probably Division of Vital Records, þ 24b. Were autopsy tindings available prior to Completed 24a. Wes en eutopsy performed? completion of causa of death? page 2 108 1 Yes 1 Yes 2 No certificate or Attending Physician: funeral director, Be 25. Wes case reterred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA After this Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Magner of Deeth 28b. Time of 28c. Injury et Work? Certification: Naturel 5 Pending 1 Yes 2 No death. 2 Accident investigation after death 6 ☐ Could not be 3 Suicide 28e. Pleca of fnjury - At home, tarm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide 24 hours a Hospital Certifier (Check only one)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner statad. 29e. Certifier Medicai within 24 hor To the Fune completely fi \$ 29d. Date signed (Month, Day, Year)

James Catavenis, M.D. State Registrar

of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signature end title of certifier

3001 Hospital Drive Cheverly, Maryland 20785

29c. Licensa number

ALL DE LES PROPERTIES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Court **Physician** 9:10AM RONEADER WOODARD 1999 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES ff Undar 1 Yaar I Undar 24 Hrs. Hours Min. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1□M 20XF Months Days Yrs 75 11-23-23 N.C Director 239-70-8769 Usuai Rasidance of Decedant with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shot fraumatic event, the Madical Evantiner must be notified at 1 Yas 2 No Directo Prince Georges Clinton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 20735 5911- Mardella Blvd. permit. Pagas 1 and 2 should be filed within 72 hours effar death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event. Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Navar Marriad Married 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Specify: Black Maryland 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondery (0-12) College (1-4or 5+) N/A 9th Unemployed 18. Mothar's Nema (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Millie Langston Alonzo Langston 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 5911- Mardella Blvd. Clinton, Md. 20735 David Woodard/Son Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Rest Haven Cemetery 4/14/99 Harnett County, N.C. 5 Othar (Specify) 22. Nama and Addrass of Facility Bianchi Funeral Service c/o Hackett's Funeral Chapel, Inc. A Funeral Sarvice Licensaa 21. Signatura 23. Part1. Enfer tha disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cerdiac or raspiretory errest, shock, or haart failura. List only one cause on each line. Approximete Intarval Between Onsat and Death Physician SCUTE GASTOUNTETTUAL BUSGOING /Medical Immediata Causa (Final disaasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner that the death cartificate be executed physician and the burial-tran Sequentially list conditions, if any, laading to Immadiate cause. Enter Undarlying Causa (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of) P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 88 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of causa of daalh? page 2 has 1 Yes 2 No 1 ☐ Yas 2 ☐ No cartificata Attending Physician: Be 25. Was cese referred to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 1 Pinpatiant 2 □ ER/Outpatient 3 □ DOA this funaral Certification: 27. Menner of Death 28a. Data of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Affar 1 Neturel 5 Pending investigation Hospital or Attending
 24 hours efter death.
 Funeral Director: Aft 1 ☐ Yas 2 ☐ No 2 Accident filled in by the 3 Suicida 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. edicai 29a. Cartifier 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number -18545 m plated causa of deeth (Item 23a) (Type, Print) OUD LINE CONTEN WALDONF, Md. 2060 n (ZOITCH MI 12070 31. Data filad (Month, Day, Year)

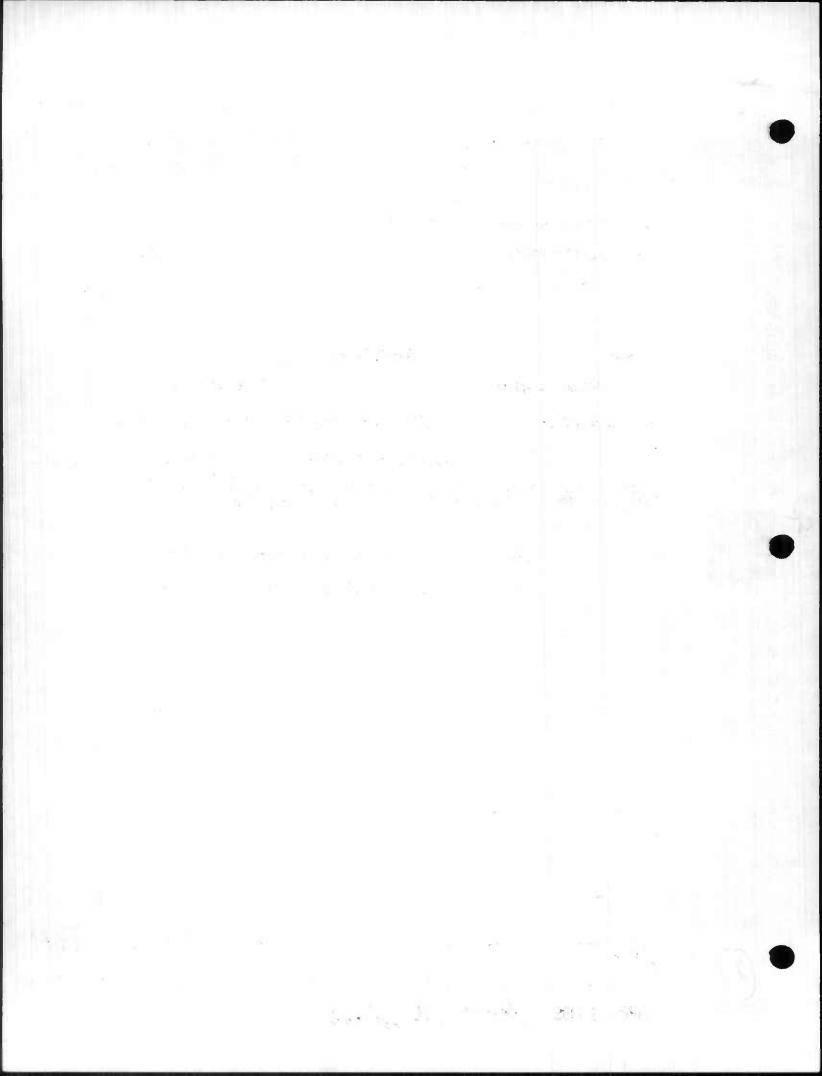
2. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

APR 0 9 1999



| | 31. PGC 1. Decedeni's Name | | | | | | | | Death | | 2. Dete of | Reg. I | 40. | | 3. Time of Deat |
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| | John Q | . B1 | echer | | | | | | M | inni | e E. | Wed | ld1e | | |
| | 19a. Informant's Na | me/Relation | nship (Type, F | Print) | | 19b. Mailir | ng Address (| (Street a | nd Numbe | er or Run | al Route No | mber, Cit | y or Town, | State, Zip | Code) |
| - | William L | | ker, J | r | | | 15th | | e, Hy | yatt | | 7 | - | | .0782 |
| 2 | 20a. Method of Dispo | | 3 | val from Ct | 0.0 | Plece of Dispo cem <i>etery, cre</i> r | natory or off | e of her place | 9) | i | Date | | Location - 0 | City or To | own, State |
| | 4 Donation | | | Variotii 36 | For | rt Lin | coln (| Ceme | tery | 0 | 4/09/9 | 9 Br | centwo | ood, | Maryland |
| 1 | 21. Signature of Fun | neral Service | e Licensee | | | | 2. Name and | | | | D | | | | |
| | Cla | ude | the | 0. 2 | Saso | -1 47 | sch's 39 Ba | run 1tim | ore A | Hom | e, r. ue. H | A. vatts | sville | . MD | 20781 |
| | 23a. Part1. Enter the shock, or heart | e disease, o | or complicatio | ons that ceu | used the deeth | h. Do not ent | er the mode | of dying | , such as | cerdiac o | or respirato | ry arrest, | | | Approximate Interval Between |
| 1 | | ranero. Lie | or only one oa | | | | | | | | | | | | Onset end Deeth |
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| P | disease or condition resulting in death) Sequentially list con if any, leading to impresses. Enter Under Cause (Disease or In thet initieled events resulting in death) Library Indiana. Part II. Other significations of the control | nditions, mediate rlying njury asst cant conditions. | Hospi | ital: 1 In Ing. Ba. Dale of (Month, | Due to (or Due to (or th but not result patient 2 Injury Day Year) | reseconsequence of the design | Quence of): Juence of): Inderlying ce The second of the | elli | 26. Place | of Death | 23b. 24a. \ (Check o me 5 1 28d. Descri | Vas an auterformed Yes Ves Nay one) Residence how Ir | 2 No stopsy ? 2 No 6 Other | 24b. W. av co of | the cause of debebly 4 Unkildere autopsy findinaliable prior to impletion of ceuse death? Yes 2 No |
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| 2 | disease or condition resulting in death) Sequentially list con if any, leading to impresses. Enter Under Cause (Disease or in thet initially devents resulting in death) Little and the initial control of th | aditions, mediate thing miury asst cant conditions. Solution in the condition in the condi | Hospi ling ling tigation d not be mined 28 | ital: 1 Ing Ba. Dale of (Month, Be. Place of building | Due to (or Due to (or Due to (or Due) to (or Due) to (or Due) the but not result the but not result the but not result the but not result the but not result to (or Due) the but not resul | or as a consect Let Let Let Let Let Let Let Let Let Let | quence of): Juence of): Inderlying ce Int 3 DO/ M Yeel, factory, In occurred a vestigation, | elling | 26. Place on in Part I. | of Death | 23b. 24a. \ 1 24a. \ 1 28d. Describer City or | Nas an auterformed Yes Vas an auterformed Yes Residence libe how in On (Street Town, St the ceuseme, date a | 2 No utopsy ? 2 No 6 Other and Number ale) s(s) and ma | 24b. W. av cood of 1[| bebly 4 Unking the cause of debebly 4 Unking the cause of debebly 4 Unking the cause of death? Yes 2 No (by) All Route Number, the cause of the cause(s) |
| 2 | disease or condition resulting in death) Sequentially list con if any, leading to impresses. Enter Under Cause (Disease or in thet initieled events resulting in death) Little and the initieled events resulting in death) Little and the initieled events resulting in death) Little and the initieled events resulting in death) Little and the initieled events resulting in death) Little and the initieled events resulting in death) Little and the initieled events resulting in the init | aditions, mediate thing miury asst cant conditions. Solution in the condition in the condi | Hospi ling ling tigation d not be mined 28 | ital: 1 Ing. Ba. Dale of (Month, Be. Place of building. | Due to (or Due to (or Due to (or Due) to (or Due) to (or Due) the but not result the but not result the but not result the but not result the but not result to (or Due) the but not resul | or as a consect Let Let Let Let Let Let Let Let Let Let | quence of): Juence of): Inderlying ce Int 3 DO/ M Yeel, factory, In occurred a vestigation, | A Other Sc. Injury Work | 26. Place on in Part I. | of Death | 23b. 24a. \ 1 24a. \ 1 28d. Describer City or | Nas an auterformed Yes Vas an auterformed Yes Residence libe how in On (Street Town, St the ceuseme, date a | 2 No utopsy ? 2 No 6 Other and Number ale) s(s) and ma | 24b. W. av cood of 1[| the cause of debebly 4 Unknown under autopsy finding allable prior to impletion of ceuse death? Yes 2 No. No. No. No. No. No. No. No. |
| 2 | disease or condition resulting in death) Sequentially list con if any, leading to impresses. Enter Under Cause (Disease or in thet initially devents resulting in death) Little and the initial control of th | aditions, mediate thing miury asst cant conditions. Solution in the condition in the condi | Hospi ling ling tigation d not be mined 28 | ital: 1 Ing. Ba. Dale of (Month, Be. Place of building. | Due to (or Due to (or Due to (or Due) to (or Due) to (or Due) the but not result the but not result the but not result the but not result the but not result to (or Due) the but not resul | or as a consect Let Let Let Let Let Let Let Let Let Let | quence of): Juence of): Inderlying ce Int 3 DO/ M Yeel, factory, In occurred a vestigation, | elling | 26. Place ar: 4 Nu at ? (es 2 1 | of Death | 23b. 24a. \ \(\text{Check o} \) me 5 \(\text{Discrete} \) 28d. Description and due to red at the ti | Nas an auberformed Yes Nas an auberformed Y | 2 No stopsy ? 2 No 6 Other njury occurr and Number s(s) and ma and place, s Date signec April | 24b. We ave of 1 [and 1 | bebly 4 Unking the cause of debebly 4 Unking the cause of debebly 4 Unking the cause of death? The cause of debebly the cause of cause of the cause |
| medical Columbiation by Tripsicial Programmed Columbiation Columbiatio | disease or condition resulting in death) Sequentially list con if any, leading to impressed in the cause (Disease or in the timileled events resulting in death) Library in the control of the control o | anditions, mediate rhying nijury asst cant conditions. Solution of the conditions o | Hospi ling tigation d not be mined 28 ing Physician of Examiner; | itial: 1 Ing Ba. Dale of (Month, Be. Place of building n: To the bes end manne | Due to (or Due to (or Due to (or The Due to | reseconsequence of the few reseconsequence of the few reseconsequence of the few reseconsequence of the few reseconsequence of the few reseconsequence of the few reseconsequence of the few reseconsequence of the few resec | quence of): nuence elling | 26. Place ar: 4 Nu at ? (es 2 1 | of Death | 23b. 24a. \ \(\text{Check o} \) me 5 \(\text{Discrete} \) 28d. Description and due to red at the ti | Nas an auberformed Yes Nas an auberformed Y | 2 No stopsy ? 2 No 6 Other njury occurr and Number s(s) and ma and place, s Date signec April | 24b. We ave of 1 [and 1 | bebly 4 Unk ere autopsy findir ailable prior to mpletion of ceus death? Yes 2 No No Route Number, stated. o the cause(s) Day, Year) |

1...

- 17

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Dete of Daeth 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) **Physician** 5:00 AM HPI IAMS atherine · /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Kenswaton If Undar 24 Hrs. 18. Data of B ensing ton k lariner tealth gomer Data of Birth (Month, Day 5. Social Sacurity Number In yrs. last birthday) 9. Birthpiaca (Stata or F raign **Funeral** Days 1 □ M 2 X F Months Min 579-36-1213 Yrs. **Director** tor 26 Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Jeorge Washing MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? S. 0 Funeral 1401 CS00 death 12. Wes Decedant Ever in U,S Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indien Bleck, White, atc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health end Mantel Hygiene. Important: If item 27 is marked other then "natural", or ite 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No þ Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Il Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 10-18. Mothar's Nama (First, Middla, Maidan Sumama) Be ANDOL 19b. Mailing Addrass (Street and Number or Ryra, Routa Number, City or Town, State, Zip Code) 19anInformant's Name/Ralationship (Type MOY Place of Disposition (Nama of cematary, cramatory or ethar place) Method of Disposition Data Buriel 2 Cremetion 3 Ramoval from Stata
4 Donetion 5 Other (Specify) 0 any Injury o 8m 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. Physician Immadiata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner ettending physicien end for use as the burial-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) certificate be exec Box 68760. Physician/Medical Dua to (or as a consaquance of): Division of Vital Records, P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the yd bengis 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of cause of daeth? 24a. Was an autopsy Completed this cartificate has 2 PNo 1 ☐ Yas 2 ☐ No or Attending Physicien: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 9 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3□ DOA 27. Manner of Death funeral 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. tnjury at Work? After 5 Panding invastigation 2 No death. 1 Yas after death 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours To the Funeral Hospital 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Cartifian Medical completaly 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end_titla of cartifiar 29c. License number 29d. Dete signed (Month, Day, Year) 00052986 30. Name and addrass of parson who complated causa of daath (Itam 23a) (Type, Print) AUTHWAY, Suitland, MD 30746 WGL JYEN MD 5160

32 Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

APR 0 7 1999

APA 11 1935 Sept 1 1 194

Helifal Balletine I was

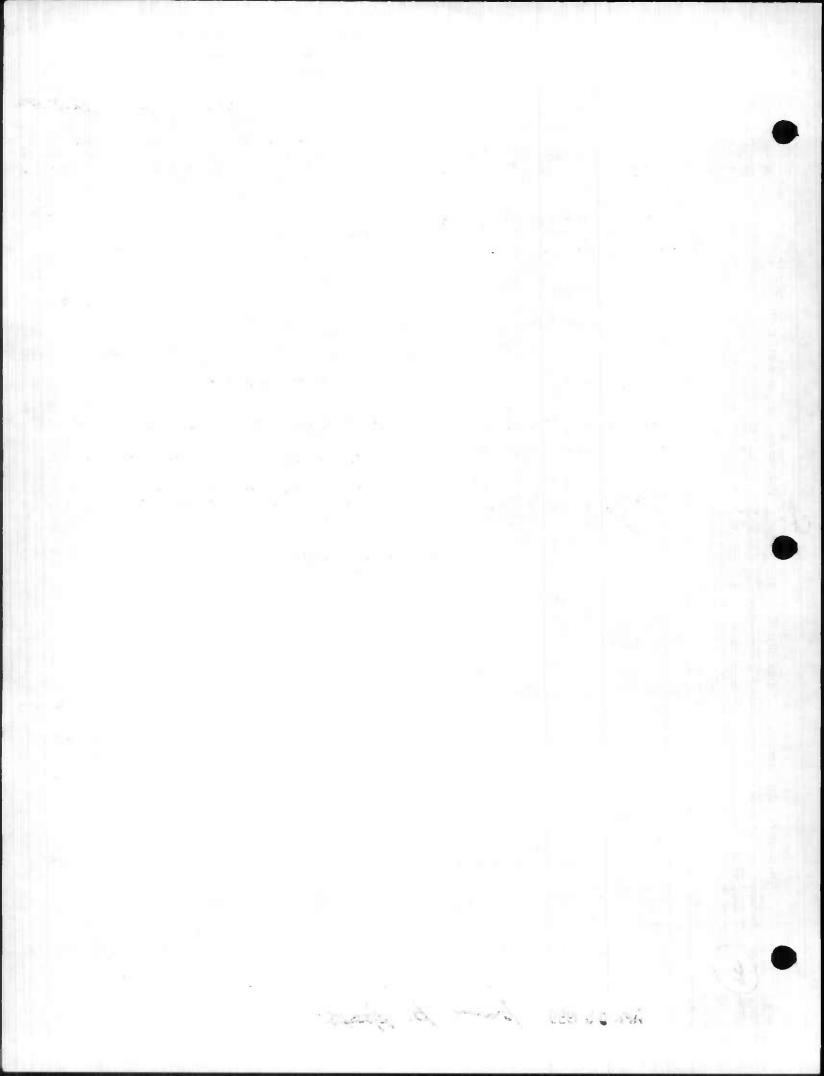
State of Maryland / Department of Health and Mental Hygiene 00 122

| | | | | Certifi | cate of | Death | Re | eg. No. | | 06.11 |
|--|--|---|-----------------------------------|----------------------------------|---------------------------------|--|--|----------------------------------|------------------------------------|--|
| Physician | 1. Decedent's Nama (First, Middla, | | | | | | 2. Data of Deat Month | | Year | 3. Time of Death |
| /Medical | Mobert Wexte | | | | | Als Oils Town and | April | 7 | 999 | 12.00 RM |
| Examiner | 4a Facility Name (If not institution, games Andrus House | iva street and number) | | | | 4b. City, Town, or Lo Betheso | 2 - | 4c. County Mont | of Death Egome | ery |
| Funeral Director | 5. Social Sacurity Number 123-07-2353 | Sex 7. Ag | ge (In yrs. last b | | Under 1 Yaar nths Days | If Undar 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day, Dec. 2 | Year) 1904 | | nca (Stata or Foreign y) New Yor |
| D . | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tox | em or Location | _ | | | | 100 | d. Inside City Limits |
| with the Maryland a or 28a-f show be notified at | | omery | Beth | | | | | | | 1 ☐ Yas ŽŽNo |
| £ 23 E | 10e. Street and Number 10910 Old Geo | rgetown 1 | Road | 10 | of. Zip Code 2 | 20852 | 1 | 0g. Citizan of V | Vhat Countr JSA | y? |
| or. | 32 Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces: 1 Yes 2 Yes If Yes, Give Yaar or Dates: | Ever In U,S. No | | Decedent of the specify Cub | Hispanic Origin? (Spoan, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | e - Amarican k, Whita, at Wh | |
| han han | 15. Decedent's (Specify only highast (Elementery/Secondery (0-12) | Education trade completad) College (1-4or | 5+) | Decedent's (Give kind life. DO N | | pation during most of work ad) | ing | Educa | | |
| snould be filed very and Mental Hygies a marked other turnatic event, in To Be Co | 7. Father's Name (First, Middle, La | | | | | 18. Mother's Nem | e (First, Middle, M | Aalden Surnam | | |
| and M and M is mari | 19a. Informant's Name/Reletionship | (Type, Print) | 19 | b. Mailing Ad | Idress (Stree | t and Number or Rur | al Route Number | City or Town, | State, Zip C | Code) |
| semit. Peges 1 and 2 should be files Department of Health and Mental Hys mportant: if Item 27 is marked other nny Injury or other traumatic event, 2008. | Koley Dworkin/ 20a. Method of Disposition | | 20b. Place | 5 Lai of Disposition | /Name of | reet, Ro | | e, MD 20c. Location - | 208 City or Tow | |
| 0 5 > | Burial 2 Cremation 3 | cify) | | | | metery | 1/5/99 | Adelph | ni, M | ID |
| permit. Pe Departmen Important: eny Injury ence. | 21. Signature of Furauri Service Lic | al Ho | me 20012 | | | | | | | |
| Physician | 23a Part Lenter the disaase, or co shock or beart failura. List on | mplications that cause ly ona cause on each li | d tha death. Do | not enter the | a moda of dy | Ing, such as cardiac | or respiratory arre | est, | 1 | Approximate Interval Between Onset and Death |
| /Medical Examiner | Immediate Causa (Final disease or condition resulting in deeth) | a | Due to (or as a | consequence | | MIA | | | 1 | 3 young |
| is a | | b | | 1 | | | | | | |
| ntificate be axecuted ng physician end as the bunal-transit Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c. | | | | | | | | | |
| | | | | | | | | | | |
| as that the death ce igned by the attendi be deteched for use by Physician/ | Part II. Other eignificant conditions | contributing to death b | out not resulting | in the underl | ying cause gi | iven in Part I. | 23b. Dld to | bacco uea cor | ntribute to t | the cause of death? |
| ned by the detection of Physics | | | | | | | 1 □ Y | e 2□ No | 3 Probe | ably 4⊠Unknown |
| been s should | | | | | | | 24a. Was a perform | n autopsy ned? | com | re autopsy findings llable prior to aplation of causa eath? |
| The law page 2 | | | | | | | 1 □ Ye | s 2N No | 10 | Yes 2 No |
| irector, pag | 25. Was case referred to medical examiner? | W = 25 A | | | | 26. Plece of Deat | h (Check only on | е) | | |
| Physician: this certific ral director, | 1 Yes 2 No | Hospital: 1 Inpation | | Outpatient 3 | LIDUA | | ome 5 Reside | | | |
| tal or Attending Prs after death. al Director: After tied in by the funers Certification: | 1 Natural 5 Pending Investigat | (Month, Da | y Year) | Injury N | 28c. inju Wo | ork? Yes 2 No | 200. Describe no | w injury occur | red | |
| al or Attendi saftar death. I Director: A of in by the fi | 3 Suicide 6 Could not determine | d 286. Placa of th | jury - At home, t c. (Specify) | arm, street, f | actory, office | | 28f. Location (St City or Town | reet and Numb n, State) | er or Rural | Route Number, |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com | 29a. Certifier (Check only one) 1 Certifying I | Phyeician: To the best aminer: On the basis o and manner st | f examination a | e, deeth occi nd/or investig | urred at the t gation, in my | lme, date and place, opinion, deeth occur | and due to the cared at the time, do | ause(s) and me ate and pieca, | enner es ste end due to t | ited. the cause(s) |
| within vithin comp | 29b. Signatura and title ot certifier | y Heres | ing | | | ise number | 2 | 9d. Data signed | | |
| (b) | | MD 3941 I | Ferrar | |) | eaton, MI | 209 | 06-47 | | |
| State | 31. Date tilad (Month, Day, Year) | Registr | ar's Signature | | | • | | | | |

DHMH 16 Rev 6/95

Registrar

APR 0 5 1999



| : #10E | 1. Decedent's Neme (First, Middle, La | | | Certificate o | f Death | 2. Dete of Dee | | | 3. Time of Death |
|--------------------|---|--|-----------------------------------|--|---|---|--------------------------------|-------------------|---|
| ysician | JAMES WI | lliams | | | | Month O 4 | O 5 | 99 | 2110 |
| Medical caminer | 4a Facility Neme (If not institution, give | | | | 4b. City, Town, or | Location of Death | 4c. County | of Deeth | |
| | UNIVERSITY | OF MARY | LAND | | Balti | nore | Bal | hmo | re City |
| al or | 243-84-1314 | CT | e (In yrs. lest bir 48 | thday) If Under 1 Yes Months Dey | | | , Year) , 1950 | Cour | plece (Stete or Foreign htry) LIARD, NC |
| | Usuel Residence of Decedent 10e. State 10b. County MD MONTGO | AFDV | 10c. City, Tow | n or Location ER SPRING | | | | 1 | 0d. Inside City Limits |
| Director | 10e. Street and Number 3355 W | . UNIVERSITY | | 10f. Zip Code | 20005 | 1 | log. Citizen of V | | |
| Funeral | 11. Meritel Stetus | 12. Wes Decedent B | Ever in U,S. | 13. Was Decedent o | 4 | Specify Yes or No- | UNITED 14. Rec | | LES an Indien, |
| by Fun | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Yeer or Detes: | No | If Yes, specify Co | | rto Rican, etc.) | | ck, White, /: BLA | |
| Completed | 15. Decedent's E (Specify only highest gra | ade completed) | | Decedent's Usuel Occ (Give kind of work dor life. DO NOT use ret | supetion ne during most of wo red) | orking | 16b. Kind of Bu | usiness/In | dustry |
| HO | Elementery/Secondery (0-12) | College (1-4or 5 | | UCK DRIVER | / SUPERVI | SOR | PRIVAT | E | |
| Be C | 17. Father's Neme (First, Middle, Last |) | | | 18. Mother's Na | me (First, Middle, | Meiden Surnan | 10) | |
| To | WILLIE WILLIAMS | | | | MARY I | NGRAM | | | |
| | 19a. Informent's Neme/Reletionship (| Type, Print) | | . Mailing Address (Stre | | | | | |
| | GONSIE L. WILLIA | MS / WIFE | | 55 W. UNIV | | | | | |
| | 20e. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 🖔 | Removel from State | cemete | Disposition (Name of ry, cremetory or other p | olece) | Date | 20c. Location - | City or To | own, Stete |
| | 4 ☐ Donetion 5 ☐ Other (Special | (y) | CART | ER FUNERAL | | 4-8-99 | GARLAN | D N. | 2.4 |
| | 21. Signature of Suneral Service Light | Ve D | | ALEXANDE | R S. POPE CKWOOD DR | FUENRAL I | | TNG.N | m 20904 |
| | 23a. Pert1. Enter the disease, or cont shock, or heart feilure. List only | olications that caused | the deeth. Do | | | | | 1110,1 | Approximete thervel Between |
| | STOOK, OF FIGURE COLORS | One carrie on egon m | | | | | | | Onset and Death |
| | Immediate Cause (Final disease or condition | 5 | epsis | | | | | | 1 Weck |
| Jer | resulting in deeth) | | Due to (or es e | consequence of): | | | | | |
| PAGITIFICA | Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or Injury | b | Due to (or es e | consequence of): | | | | | |
| lical | that initiated events resulting in deeth) Lest | С. | Due to (or es e | consequence of): | | | | | |
| Physician/Medi | L | d | | | | | | | |
| clan | Dart II. Other all-attended and state | | 15 mas | Alexander de des | along to Day 1 | ORE DUT | -hase- | | o the games of do to |
| by ruys | Pert II. Other algnificant conditions of | contributing to death bu | ut not resulting i | n the underlying cause | given in Pert I. | 1 🗆 1 | | | o the cause of death bably 4 - Unknow |
| Completed | | | | | | 24e. Wes e | en eutopsy med? | 6/ | ere autopsy findings reliable prior to empletion of cause deeth? |
| 5 | | | | | | 1 U Y | es 2 No | 1 | ☐ Yes 2☐ No |
| De C | 25. Wes case referred to medical | | | | 26. Plece of De | seth (Check only o | | | |
|) | exeminer? | Hospitel: 1 Inpatie | nt 2 ER/Ou | itpatient 3 DOA | Other: 4 Nursing | Home 5□ Resid | ence 6 Oth | er (Speci | fy) |
| ation: | 27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigatio | 28e. Date of Injur (Month, De) | y Year) 28b. | Fime of njury M 1 | jury et vork? □ Yes 2 □ No | 28d. Describe h | ow injury occur | red | |
| Certification: | 3 Suicide 6 Could not be determined | | ury - At home, fe :. (Specify) | rm, street, fectory, office | ×e · | 28f. Location (S City or Tow | | per or Run | al Route Number, |
| () | (Check only 2 Medical Exam | nysician: To the best on miner: On the basis of end menner sta | examinetion en | , deeth occurred et the d/or investigetion, in m | time, dete end pled y opinion, deeth occ | e, and due to the curred et the time, c | cause(s) and modele end place, | enner as a | stated. o the cause(s) |
| edical | one) | end menner sta | ilea. | | | | | | |

DHMH 16 Rav 6/95

State Registrar 31. Dete filed (Month, Day, Year)

APR 0 8 1999

State of Maryland / Department of

| Health and Mental | Hygiene (| 1 | 2 | 2 | 3 |
|-------------------|-----------|-----|---|------|------|
| f Death | Don No. | - 1 | 6 | 5.00 | 1 67 |

| | | | Ce | rtificate o | f Death | | Reg. No. | 100 | w 1 % |
|---|--|--|--|--------------------------------|--|---|------------------------------|-------------------------------|---|
| Physician /Medical | 1. Decedent's Neme (First, Middle, La Sylvester N | * | heeler | | | 2. Dete of De Month APRIL | Day | 499 | 3. Time of Death |
| Examiner | 4e Facility Neme (If not Institution, gives | LAND HOSE | | TER If Under 1 Ye | CLINTO | | PRINC | E GE | FORGES |
| Funeral Director | | Sex 7. Age 1□XM 2□ F | (In yrs. lest birthday 65 Yrs. | Months De | | n. (Month, De | 11, 1934 | | ce (Stete or Foreign |
| ector | 10a. Stele 10b. County District of Col | | 10c. City, Town or L | ocution Washing | ton | | | 100 | d. Inside City Limits |
| from rount by notified Funeral Director | 10e. Street and Number 191 - 54th St | ., S.E. | | 10f. Zip Cod | | | 10g. Citizen of V | | y? States |
| by | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent E Agned Forces? 14 Yes 2 No If Yes, Give Yeer or Detes: | | Wes Decedent of Yes, specify C | of Hispenic Origin? uban, Mexicen, Pue lo Specify: | (Specify Yes or No erto Ricen, etc.) | Bled | e - American ck, White, et | c. |
| Completed | 15. Decedent's E (Specify only highest gro Elementery/Secondery (0-12) I 2 th | ducation ade com <i>pleted)</i> College (1-4or 54 | (Give | DO NOT use ret | ne during most of w | rorking | 16b. Kind of Bo | ernmer | |
| o Be Co | 17. Fether's Neme (First, Middle, Last S. Gaddis |) | | | 18. Mother's N | eme (First, Middle Audrey Wh | , Meiden Sumen | | |
| | 19e. Informent's Neme/Reletionship (Marie Wheeler 20e. Method of Disposition 1 | - Wife | 191 20b. Plece of Disp cemetery, cre | - 54th osition (Neme of | | , Wash., | D.C. | 20019 City or Tow | m, Stete |
| 9000 | 4 Donetion 5 Other (Special Signature of Funerel Service Lice | (y) | | 2. Neme end Ad | onal Cem. dress of Fecility enning Ro | Stewart | Funeral | | |
| attending physician and for use as the burial-transit claryMedical Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest | b | Oue to (or es e conse | quence of): | | | | | |
| Physicla | Pert II. Other eignificent conditions of DIABETES | contributing to deeth but | t not resulting In the | underlying ceuse | given In Pert I. | | tobacco uee co | ntribute to | the cause of death' |
| Completed by | OBESITY | | | | | 24a. Wes | s en autopsy ormed? | evai | re eutopsy findings leble prior to upletion of cause eeth? |
| Be Comp | 25. Wes cese referred to medicel | | | | 26. Plece of E | 1 □ | Yes 2 No | 10 | Yes 2□ No |
| the funeral di | examiner? 10 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | | | of 28c. I | Other: 4 Nursing Nursi | | how injury occur | red | |
| etely filled in by | 4 Homicide determined | 28e. Piece of Injurbuilding, etc. | | | | City or To | (Street and Numilian, Stete) | | |
| completely filled in | (Check only one) 29b. Signature and the objection | miner: On the besis of e end menner sta) | examinetion end/or le | nvestigetion, in m | y opinion, deeth oc | curred et the time | , dete end plece, | and due to | the ceuse(e) |
|) | 30. Name end address of person who | completed datuse of de | ath/(llem 23a) (Type | Print) | 03395 DRIVE | 74 | APPIL RLY M | 07, | 1999 1NO 2078 |
| 44 | MAKLO = GOL | 1 1 | W | | | A11 - 1- | 10 . 1 /4 | - 13. 1 - | 110 11070 |

DHMH 16 Rav 6/95

| | ITEMS: #23 PART 1, 27. | 28A-F PFR M | 5-19-99 I | WR Ce | rtificate | e of | Death | | | Reg. No. | | |
|--|--|--|---|---|--|---|---|-------------------------|--|--|---|--|
| 20 | 1. Decedent's Name (First, Middle, | Last) | | | | | | l | 2. Date of Dec | ath Day | Year | 3. Time of De |
| an cal | Hunter Jam | | | | | | | 1.0 | APRIL | 9, 1 | 999 | 10:15A |
| ner | 4a Facility Name (If not institution, g | rive street and numbe | er) | | | | | | ation of Death | 2 | | |
| | 30 MUSKET COURT 5. Social Security Number 6 | Sex 7. / | Age (In yrs. last | hirthday |) If Under | | FANEYTO | | P Date of Birt | CARR | | lane (Ctate or Fr |
| | 215-53-4805 | 1 M 2□F | ngo (ni yra. mai | Yrs. | Months | | Hours | Min. | B. Date of Birt (Month, Da Aug 2. | | | place (State or Fo |
| | Usual Residence of Decedent | | | | | | | | Aug Z. | 1990 | Mar | yland |
| · | 10a. State 10b. County | | 10c. City, T | own or L | ocation | | | | | | t | Od. Inside City L |
| Director | MD Carr | oll | | | | | town | | | | | Y Yes 2[|
| P | 10e. Street and Number | | | | 10f. Zip | Code | 21787 | | | 10g. Citizen of | | |
| Funeral | 30 Musket Court | 12. Was Deceder | at Euror in 11 S | 112 | Was Danad | lost of l- | | n? /Sna/ | ifu Vac or No. | 14 Rac | US. | |
| nn | 11. Mantal Status 1 ☑ Never Married 2 ☐ Merried | Armed Forces | s? | 13. | If Yes, spec | ify Cub | an, Mexican, | Puerto R | ify Yes or No- ican, etc.) | Ble | ck, White, | etc. |
| by 1 | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates | | | Ti□ Yes 2 | 2 No | Specify: | | | Specif | y: Wh | ite |
| | 15. Decedent's | | 1 | | edent's Usua | | | . 4 4 | | 16b. Kind of B | usiness/In | dustry |
| eld. | (Specify only highest g Elementary/Secondary (0-12) | College (1-4o | r 5+) | life. | DO NOT us | e retire | during most of d) | or workin | | | | |
| Completed | 0 | | | | None | | | | | | None | |
| 8 | 17. Father's Name (First, Middle, La | | | | | | | _ | | Msiden Sumer | ne) | |
| 2 | | Zimmerman | 1. | | | 400 | | onda | | Warman | O: | 0.73 |
| | 19a. Informant's Name/Relationship Mr. & Mrs. James | (Pa | rents | | | | | | | or, City or Town 21787 | , State, Zip | Code) |
| | 20a. Method of Disposition | 1. ZIIIIREI | 20b. Place | e of Disp | osition (Nan | ne of | | leyto | Date Date | 20c. Location | - City or To | wn. Slate |
| | Burial 2 ☐ Cremetion 3 | | | iemetory or other place) iew Mem. Park | | | 4 | 4/13/99 Sykesville | | | | |
| | 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic | | | - | | | ss of Fecility | - | 15/55 | Dynes | VIIIC | , DE |
| | 1 STIAN & | baidt | | | HAIGH | T FU | JNERAL | | | APEL (Bo | | 5) |
| | 23a. Part1. Enter the disease, or co shock, or heart feilure. List on | mplications (Mat caus | ed the death. [| Do not en | Sykes | vil. | le, MD | 217 | 84 (41) |) - 795- 1 | 1400 | Approximate |
| | shock, or heart feilure. List on | ly one cause on each | line. | | | | | | | | | Intervel Between |
| | | | | | | | | | | | 1 | Onset and De |
| | Immediate Cause (Finel | | SHEEDCA | | | | | | | | | Onset and De |
| | | a | SUFFOCA | ATION | | | | | | | 1 | Onset and De |
| Iner | Immediate Cause (Finel disease or condition | a | | ATION | | | | | | | 1 | Onset and Dec |
| xaminer | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, | a | | ATION s a conse | equence of): | | | | | | | Onset and De |
| Ä | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | b | Due to (or es | ATION s a conse | equence of): | | | | | | | Onset and De |
| Ä | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | a b | Due to (or es | ATION s a conse | dneuce ot): | | | | | | | Onset and De |
| Ä | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | b | Due to (or es | ATION s a conse | dneuce ot): | | | | | | | Onset and De |
| Ä | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | | | | |
| Ä | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | a b c d contributing to death | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | 23b. Did | | | o the cause of c |
| Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | 23b. Did | lobacco usa co | | o the cause of d |
| by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a b c d contributing to death | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | 23b. Did 1 | lobacco usa co | 3 ☐ Pro | o the cause of debeloy 4 Under autopsy find silable prior to |
| by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a b c d contributing to death | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | 23b. Did 1 | robacco use co Yes 2 no an autopsy | 3 ☐ Pro | o the cause of c bably 4 Un ere autopsy find silable prior to |
| by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | | | | 23b. Did to 1 1 24a. Was perfo | robacco use co Yes 2 no an autopsy | 3 Pro | bably 4 Un |
| Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): | ause giv | ven in Pert I. | | 23b. Did to 1 1 24a. Was perfo | tobacco use co Yes 2⊠No an autopsy med? Yes 2□No | 3 Pro | o the cause of cobably 4 Undere autopsy find silable prior to mpletion of caudeath? |
| To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 10. Yes 2 No | Hospital: 1 ☐ Inpa | Due to (or es | ATION s a conse s a conse s a conse | equence of): quence of): underlying countrying countr | ause giv | zen in Pert I. 26. Place (ner: 4∐ Nurs | of Deeth | 23b. Did 1 1 24a. Was perlo 1 7 (Check only c | Nobacco use co Yes 2 No an autopsy med? Yes 2 No whe) | 3 Pro 24b. W av co of 1[| o the cause of cobably 4 Under und |
| To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | Hospital: 1 ☐ Inpa 28a. Date of In (Month, L | Due to (or es Due to (or as Due to (or as but not resultin tient 2 ER | ATION s a conse | quence of): quence of): quence of): underlying compared to the compared to | ause giv | 26. Place oner: 4 □ Nurs | of Deeth Sing Home | 23b. Did to 1 24a. Was performed to 1 24a. Was performed to 1 25 Resident | tobacco use co | 3 Pro | bably 4 Undere autopsy find silable prior to impletion of cau death? |
| To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 1 \(\text{Nanner of Death} \) 1 \(\text{Nanner of Death} \) 1 \(\text{Natural} \) 2 \(\text{Accident} \) 3 \(\text{Suicide} \) 6 \(\text{Could not} \) | Hospital: 1 Inpe 28a. Date of In (Month, E | Due to (or es Due to (or es Due to (or as Due to (or as but not resultin tient 2□ER jury 2er) 1999 F0 | ATION s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse | equence of): quence of): quence of): underlying compared to the compared to | ause giv | zen in Pert I. 26. Place (ner: 4∐ Nurs | of Deeth sing Hom | 23b. Did to the control of the contr | an autopsymed? Yes 2 No No No No SUFFOCAT | 3 Pro 24b. W av co of 18 her (Special | o the cause of c bably 4 Un ere autopsy find silable prior to impletion of causideath? Fres 2 No. |
| To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat | Hospital: 1 Inpe 28a. Date of Information APRIL 9, be did 28e. Place of Inbuilding. | Due to (or es Due to (or es Due to (or as Due to (or as but not resultin tient 2 ER jury 2er) 26 Typy Year) 7 Typy Year) FO njury - At home etc. (Specify) | ATION s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse s a conse | equence of): quence of): quence of): underlying compared to the compared to | ause giv | 26. Place oner: 4 □ Nurs | of Deeth sing Hom | 23b. Did to 1 24a. Was performed to 5 Resking Bd. Describe IDECEDENT | an autopsymed? Yes 2 No No No No SUFFOCAT | 3 Pro 24b. W ave co of 1 le ther (Special med | o the cause of control of cause of control of cause of ca |
| Certification: To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions Part II. Other significant conditions 25. Was case referred to medical examiner? 1 VA yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not determine | Hospital: 1 ☐ Inpa 28a. Date of In (Month, I APRIL 9, be d 28e. Place of I building, | Due to (or es | ATION s a conse | quence of): quence of): quence of): underlying count 3 DO of A 2 M Ireet, fectory | ause giv | 26. Place of the second secon | of Deeth sing Horr | 23b. Did 1 1 24a. Was perfo (Check only one 5 to Reside Bd. Describe I DECEDENT St. Location (Schy or Tow | Nobecco use co | 3 Pro 24b. W aw co of 1 [ther (Special red FED IN ber or Rura MUSKET AND | o the cause of bebty 4 Ur ere autopsy fine silable prior to mpletion of cau death? Effect 2 No. No. No. No. No. No. No. No. No. No. |
| To Be Completed by Physician/Medical Ex | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Natural 5 Pending 2 Accident 5 Pending 1 Suicide 6 Could not determine 1 Pendicide 1 Pendicide 1 Pendicide | Hospital: 1 Inpe 28a. Date of Information APRIL 9, be did 28e. Place of Inbuilding. | Due to (or es Due to (or es Due to (or as Due to (or as but not resultin titient 2□ER tipury lay Year) 26 1999 Fo injury - At home efc. (Specify) RESIDENCE of examination | ATION s a conse | quence of): quence of): quence of): underlying comment 3 DO of A 2 M Ireet, factory | ause given | 26. Place of the result of th | of Deeth sing Hom 2 o [| 23b. Did (1 24a. Was perio 1 25 Reside Bd. Describe I Bf. Location (City or Tow | tobacco use co | 3 Pro 24b. W av co of 18 her (Special rred FED IN ber or Rura MUSKET AND anner as s | or the cause of bebly 4 U ure autopsy fin slable prior to impletion of cardeath? SYes 2 N CRIB Il Route Numb. COURT tated. |

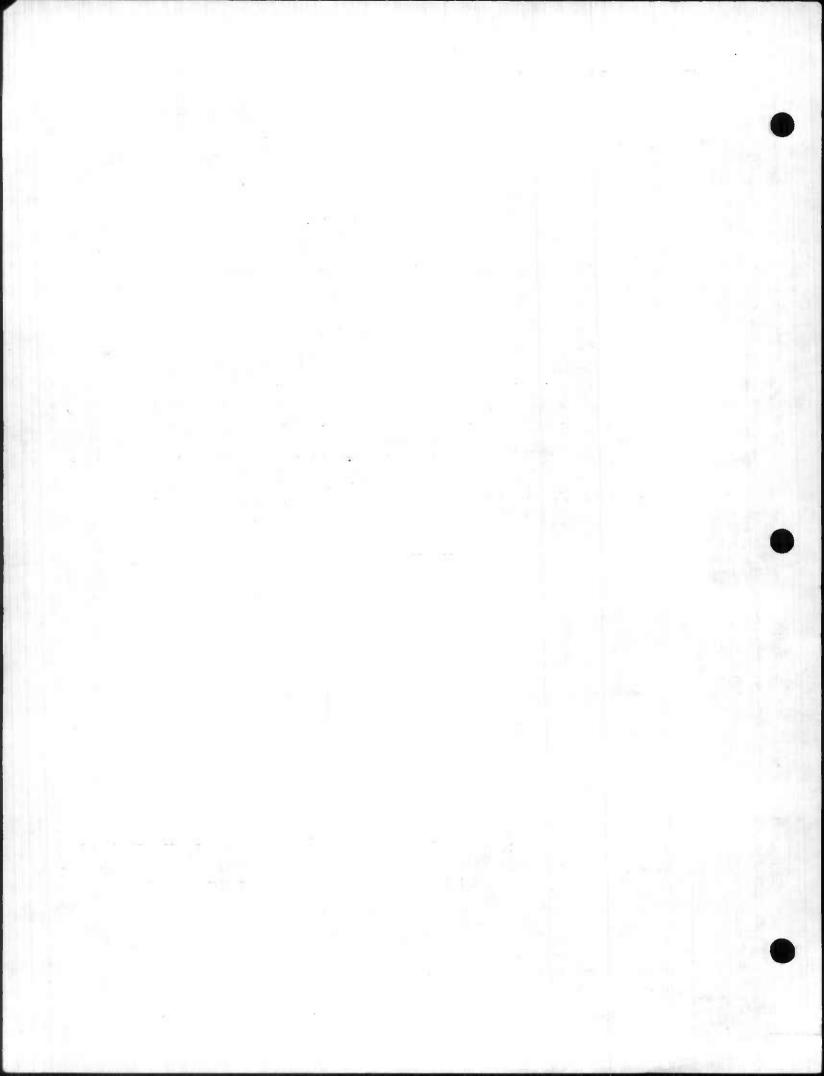
State Registrar

31. Date filed (Month, Day, Year)
APR 1 4 1999

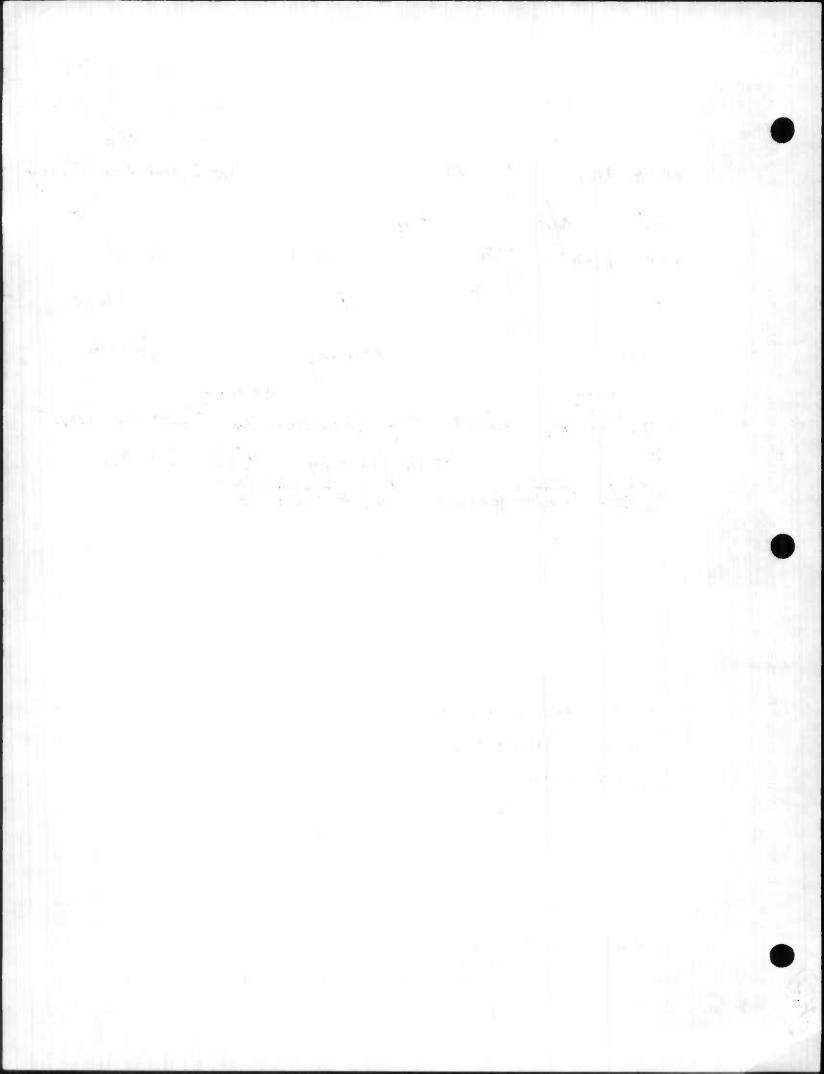
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

APRIL 10,1999

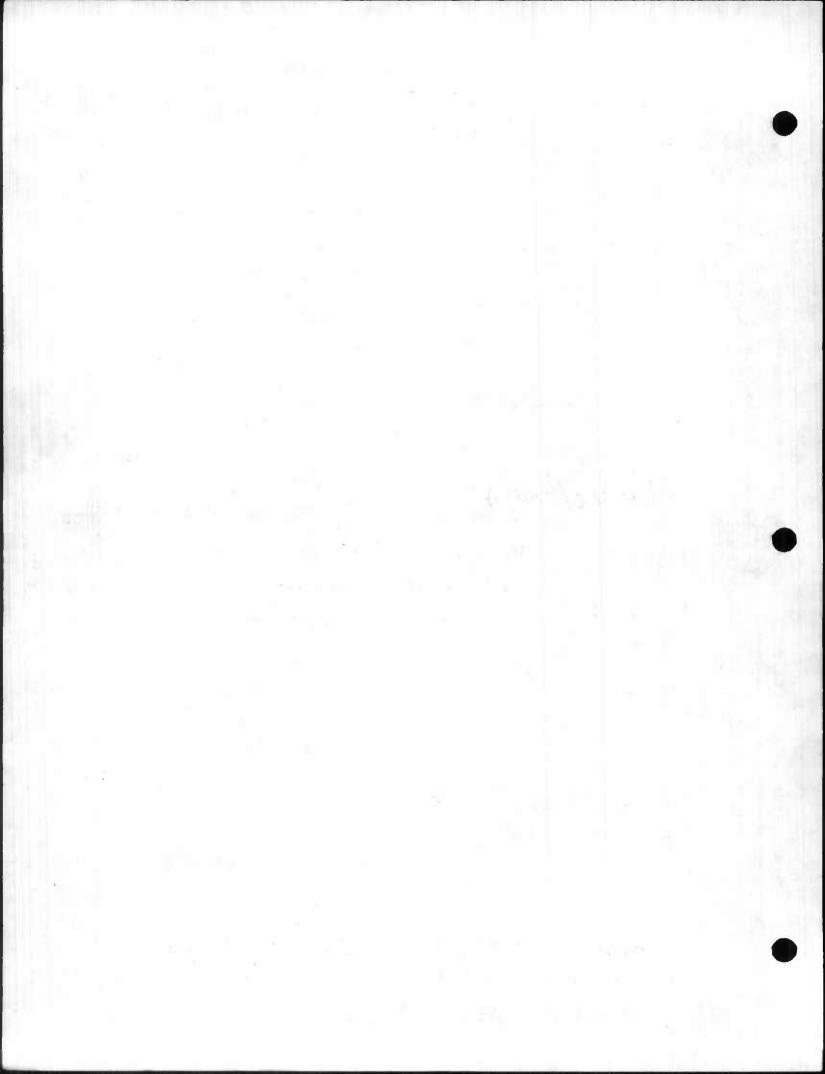


Please Type or Print in Biack indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Day Month **Physician** 1:08 PM VIOLA ADAMS APRIL 1999 20 /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Montha Days Hours Min. North, Day, Lpt 30 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign **Funeral** Montha New 1□M 20 F Yrs. 216 - 40 - 142 4 Usual Residence of Decedent 70 Director permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is merked other than "natural", or items 23s or 28s-1 show eny injury or other treumatic avent, to a Medical Examinal must be notified and 2008. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 1213 Completed by Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 4. Rece - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ₺No Specify: Specify: Black 3 D Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) College (1-4or 5+) unk Nursing 8. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be UNKNOWA unknown 19b. Malling Address (Street end Number or Rurel Route Number City or Town, Stete, Zip Code) 19a. Informant's Neme/Pelationship (Type, Print) friend 20b. Place of Disposition (Name of cemetery, cremetery or other p Wilbert 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 □ Other (Specify) Zion Cemetery 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. c Cullah Approximate Interval Between Onset and Death **Physician** PNEUMONIA /Medical Immediate Cause (Final FOUR DAYS disease or condition resulting in death) Examine Dua to (or as a consequance of): Physician/Medical Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequenca of) 98 use Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown UPPER GASTROINTESTINAL BLEEDING by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed DIABETES MELLITUS DEMENTIA 1 ☐ Yes 2 No 1 ☐ Yea 2 ☐ No certificate or Attending Physician: 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No VSInpatient 2 □ ER/Outpatlent 3 □ DOA Certification: To After this funeral 28a. Data of Injury (Month, Dey Yeer) 27. Mannar of Daath 28b. Time of 28c. Injury at Work? 28d. Describa how injury occurred 5 Pending 1. Natural after deeth. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datermined n 24 hours after der ne Funeral Director pletely filled in by th 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 | Homicida Hospital 29a. Cartifiar Tertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. To the Within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier Archane & Shameler. 1999 RESODO APRIL 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) 2/225 ARCHANA K SHYAMSUNDER, HARBOR HOSPITAL CENTER, BALTIMORE 31. Date filed (Month, Dey, Year) 32. Ragistrar's Signature State Registrar books 1999



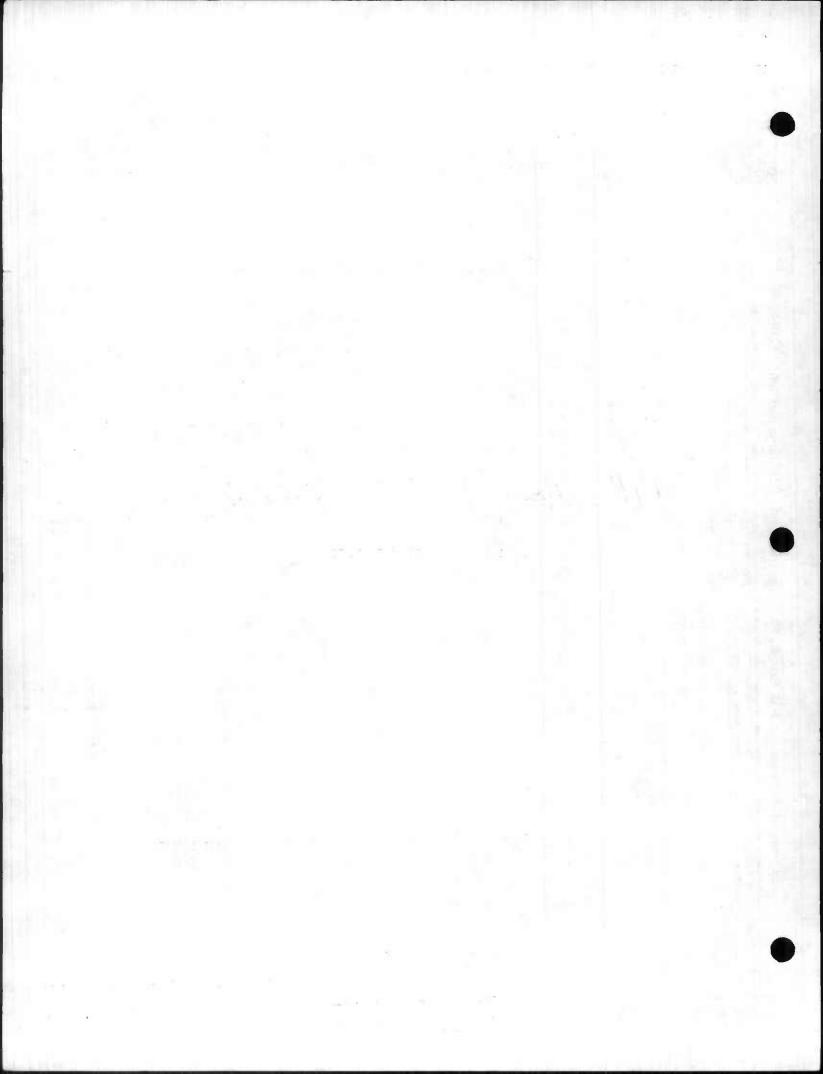
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death Reg. No. | |
|--|--|--|
| Physician /Medical | April 19 19 | 99 8 P.M |
| Examiner | Liberty Medical Center | |
| Funeral Director | [[7 7 0 4 1 0 1 2] | Birthplace (State or Foreign Country) BALTO • |
| ahow stat | 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| rector | BALTIMORE BALTIMORE | 1 No Yes 2 No |
| 2 0 | 10e. Street and Number 2510 Edgecomb Cic. Apt. D 10f. Zip Code 21215 | of Country? |
| by Funeral | 3 Widowed 4 Divorced If Yes, Give 1 Yes 2 No Specify: Specify: | American Indien, White, etc. BLACK |
| Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 10 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) N / A N / A | ness/Industry |
| Ве Сотр | | |
| 2 | GILBERT ANDERSON GAIL L. SHURMAN | |
| theur theur | 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State of Street Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Rou | ate, Zip Code) 2 1 2 1 7 |
| any injury or other traumatic event, once. To Be C | 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Cit | |
| 5 | MD Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) MT. ZION CEMETERY 4-26-99 BALTO | O. MD |
| any injury | 21. Signature of Fundral Service Licensee 22. Name and Address of Facility LEROY O DYETT & SON FUNERAL H. | IOME |
| | 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Inlerval Between |
| an cal ner | Immediate Cause (Finel disease or condition resulting in death) a. Pulmonary in-farcts | Onset and Death Terminal |
| 2 | Due to (or as a consequence of): | terminal |
| Examiner | | Vear |
| Medical Examir | resulting in death) Last Due to (or as a consequence of): | 1015 |
| / Physician/N | 2 | |
| by Physician/M | | Probably 4 Unknown |
| Completed by P | | 24b. Were eutopsy findings eveilable prior to completion of cause of death? |
| Com | 1) Yes 2□No | 17 Yes 2□ No |
| Be Be | 25. Was case referred to medical examiner? | / \ |
| | A imperior 2 La voutparior 3 Loon 4 La residence 6 Lottre | |
| Certification: | 2 Accident 3 Suicide 4 Homicide Investigation 5 City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number-City or Town, Stete) | or Rural Route Number, |
| edical C | | er as steted. If due to the ceuse(s) |
| completely filled in by the funeral Medical Certification: | | Month, Day, Year) 2) 1999 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolphin Stocal, Balto, N | 1021217 |
| CONTRACTOR OF | 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| ASP ITEMS: #23 | PART I, 27, 28A-F PER ME | State of Maryland | | | | | giene Reg. No.9 | 13 | 217 | | | |
|---|--|---|---|---|---|---|---|--|--|--|--|--|
| Physician | Decedent's Nama (First, Middle, Las | Decedent's Nama (First, Middle, Last) Mon Decedent's Nama (First, Middle, Last) | | | | | | | 3. Tima of Death 9:36 A | | | |
| /Medica Examiner | 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | | | | | | | | | | | |
| Funeral Director | Social Security Number 6. Security Number | | last birthday) If Under 1 Y Yrs. Months De | | | 8. Dete of Bir | | 9. Birthplaca (State or Foreign Country) GREENVILLE S | | | | |
| | Usuel Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Loc | ation | | 10 00 | | | 10d. Inside City Limits 1XI Yes 2 □ No | | | |
| vith the Ma | MD N/A 10e. Street and Number | | BALT | IMORE 10f. Zip Code | | | 10g. Citizen of 1 | What Country? | | | | |
| ar death v | 725 N. Milton 11. Marital Status 12 Never Merried 2 Married 3 Widowed 4 Divorced | A V ∈ n u ∈ 12. Wes Decedent Ever in U,s Armed Forcas? 1 □ Yes ≥ √ □ No If Yes, Give Yeer or Detes: | | | 1 2 0 5 tispanic Origin? (tan, Mexican, Pual Specify: | Specify Yes or No rto Rican, etc.) | U · S · A · 14. Race - American Indien, Black, White, etc. Specify: B L A C K | | | | | |
| 2121 3 within glens. r then | 15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12) | | (Give k life. D | ont's Usuel Occup ind of work done O NOT use retire ELF – EM | during most of wo d) | orking | 16b. Kind of Business/Industry LABORER | | | | | |
| yland 2 yland 2 suld be filed Mental Hygianted other ettc avent, II | 17. Father's Neme (First, Middle, Last) ROBERT AGNEW | | | | | ame (First, Middle, Maiden Sumame) FINE HOLMES | | | | | | |
| | 19a. Informent's Neme/Reletionship (T CHRISTINE MCCO | | | | and Number or R | | | | | | | |
| 2 2 2 2 . | 20e. Method of Disposition 1 Burial 2 Cramation 3 4 Donetion 5 Other (Specify, | Removal from State | metery, cremi | ition (Name of atory or other pla cemet | | Dete 1 - 24 - 99 | 20c. Location BALTO | | vn, State | | | |
| Baltimo permit. Page Department Important: If any Injury or DRG. | 22. Nama and Addrass of Facility LEROY O DYETT & SON FUNERAL HOME 4600 LIBERTY HGHTS AVE. BALTO, MD 2120 | | | | | | | | | | | |
| Physician /Medical Examiner | 23 Pert1. Enter the disease, or comp shock, or heart feilure. List only of the composition of the compositio | irrest, | | Approximete Intervel Between Onset and Deeth | | | | | | | | |
| BOX 68/60, sath certificate be executed attending physicien and for use as the burial-transit | Cause (Diseese or Injury that initieted events resulting in death) Last | с. | es a consequ as a consequ | | | | | | | | | |
| D the pt of | Pert II. Other significant conditions co | ntributing to death but not resu | Iting in the un | ven in Part I. | 23b. Did | 23b. Did tobacco use contribute to the cause of death | | | | | | |
| L X D . | | | | | | | | | ably 4月 Unknown | | | |
| aw requirements been 2 should | | | | | | | an autopsy ormed? | eva | re eutopsy findings illable prior to npletion of cause leath? | | | |
| Vital Rician: The Londiticate har rector, page | 25. Wes case referred to medical | | | | 26. Piaca of De | 1 🗵 | Yes 2□No | 112 | Yes 2□ No | | | |
| n of Vita g Physician: er this certific neral director, | 1 ∑ Yes 2 □ No | 28a. Dete of Injury | ER/Outpatient 28b. Time of Four of | 3 DOA OII | her: 4 Nursing | Home 5□Res | | | SCENE | | | |
| DIVISION OF BATTER OF Attending Phy Is after death. In Director: After this ed in by the funeral Certification: T | 1 □ Neturel 5 □ Pending Investigetion Investigetion 2 □ Accident □ Restrict □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident □ Accident | 28f. Location | T INGESTED DRUGS on (Street and Number or Rural Route Number, Town, State) NOWN | | | | | | | | | |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert | | sician: To the best of my know ner: On the basis of examineti end mennar stated. | | | | | | | | | | |
| To the comp | 29b. Signatura and titla of certifier Atyph | & Mad | EJ, MI | 29c. Licen. | | | 29d. Date signe APRIL 1 | | | | | |
| State Registrar | 30. Neme and address of person who could be seen and address of person who could be seen a seen and se | Radentz 32; Augistrar's Signatu | MO | | n Street | , Baltin | nore, Ma | rylan | d 21201 | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decadent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 46 An Month **Physician** 211 uar 185 NEZYSDUTE ' /Medical 4a Facility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. MERCY ENTER NIA MEDICAL Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Dete of Birth (Month, Dey, Year) **Funeral** Min 12M 20 F Months Days Hours Yrs. 242-14-1103 Director 08-08-13 Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryler Department of Health end Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be not tried. 1 Yes 2 No NIA BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4928 WESTHILLS KOAD USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Biack, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Merried 2 Merried Specify: BLACK 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: λq 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Sacondary (0-12) College (1-4or 5+) NIA DUPERVISOR HOSPITAL JANITORIAL GED 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Be DICKERSON ANDERSON HATTIE WYLE 2 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) BETHNAL NATHANIEL BALTO ANDERSON 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State FME/ERY 23-99 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility VAUGHN C. GREE GREENE FUNERAL 5 | 5 | BALTO NATE PIKE, BALTO.
List only one ceuse on each line. BALTO. MD. Approximete Intervel Between Onset end Deeth Physiclan /Medical Immediete Ceuse (Finel Prostatic Carcinoma Metas diseese or condition resulting in death) Examiner Examiner physician end s the burial-transit Saquentially list conditions, if eny, laeding to immadiate causa. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) attending ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac by 24b. Ware autopsy findings aveilebla prior to completion of cause of daath? Completed 24a. Wes an eutopsy page 2 hes 1 Yes 2 Ho 1 Yas 2 No certificete Division of Vital To the Hospital or Attending Physician: within 24 hours eiter death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Wes case referred to medical Be 26. Place of Death (Check only ona) SUBACUTE L Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Panding Investigation 1 Yes 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 4 Homicida Certifying Physicien: To the best of my knowledge, daath occurred et the time, dete end place, and dua to tha cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred at tha tima, data end place, and due to the cause(s) and mannar stated. edical 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Attending

completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

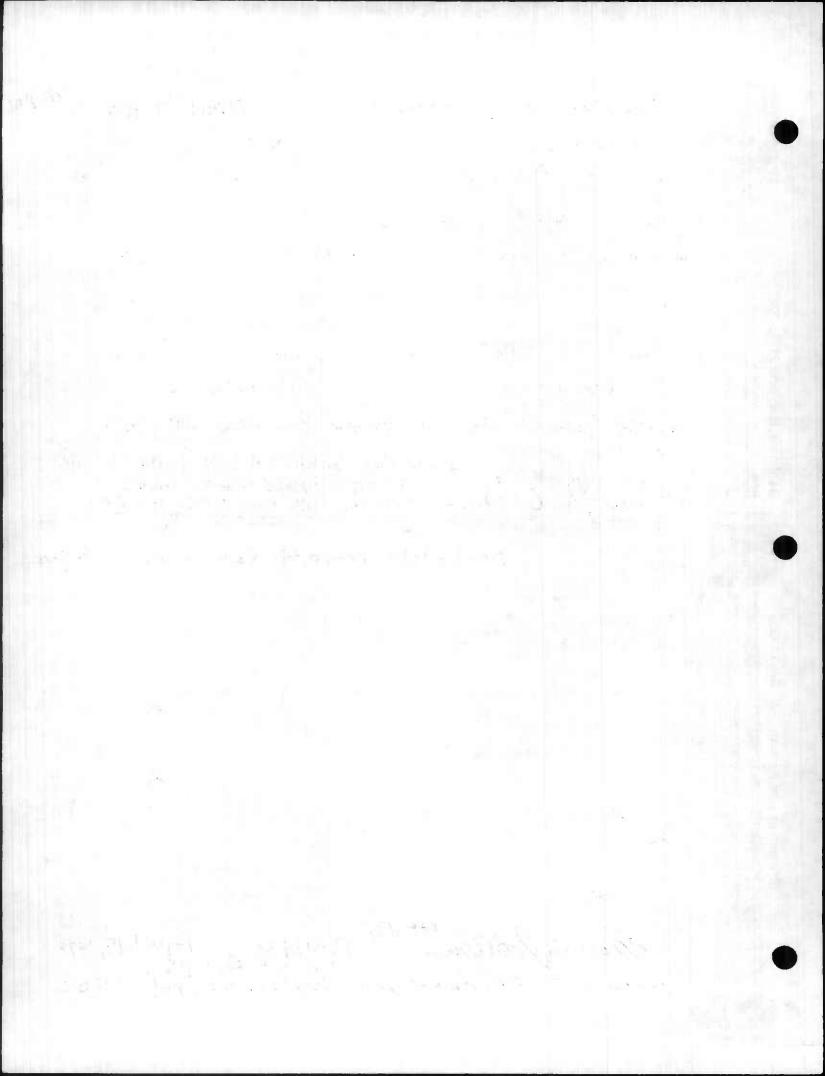
DMAN

t. 6011

Saltimore

State Registrar 30. Nema and addrass of person who

31. Dete filed (Month, Dey, Year)



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death APRIL :56 PM 16 ADAMS 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Elizabeth Nursing Home N/A Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 06/25/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex 214-24-320 1 M 2 M Months Days Hours Min Yrs. 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Ellicott City 10f. Zip Code 10g. Citizen of Whet Country? 21042 USA 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No Specify: Specify: White

CATONSVILLE, MD

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Ware autopsy findings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

the Meryland 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Madical Examiner must be notified at MD Howard Director 10e, Street and Number with 3233 Brookmede Road Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Yeer or Detes: 11. Merital Status 72 hours efter 1 Never Merried 2 Merried Maryland 21215-0020 py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) d 2 should be filed within 72 th end Mental Hygiene.
7 Is merked other than "ru Elamantary/Secondary (0-12) Collage (1-4or 5+) 12 Secretary College 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) To Albert J. Stengel Margaret Robinson 19b. Mailing Address (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health end Important: if Item 27 is m any injury or other traun Samuel H. Adams, Jr/Husband 3233 Brookmede Road, Ellicott City, Md21042 altimore. 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition Dete XIX Buriel 2 Cremetion 3 Removal from Stete 4 □ Donetion 5 □ Other (Specify) Baltimore National Cem. 4/21/99 Baltimore, Md. 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Sterling-Ashton Schwab Funeral Home, Inc 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or haert failura. List only one ceuse on each line. may K. marsha **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) **Examiner** Examiner ZHEIMEN physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Dua to (or es e consequence of): Box 68760. certificate be Physician/Medical Due to (or es a consequence of): 88 980 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 10 Purmonary DISBASE OBSTRUCTIVE 2 24a. Wes en eutopsy performed? Completed page 2 1 ☐ Yes Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Tursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA sins 27. Manner of Death 28e. Dete of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Certification: 1 Natural 5 Pending s after deeth. 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide ŏ 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian Medical completely (Check only one) To the P within 2 To the I 29b. Signature end title of certific 29d. Date signed (Month, Day, Year) 29c. License number

30. Nama and eddress of person who complated ceuse of deeth (Item 23e) (Type, Print)

POUTON, MD

31. Dete filed (Month, Day, Year) APR 2 2 1999

700 GEIPE RO

32. Registrer's Signature

State Registrar

Physician

/Medical

Examiner

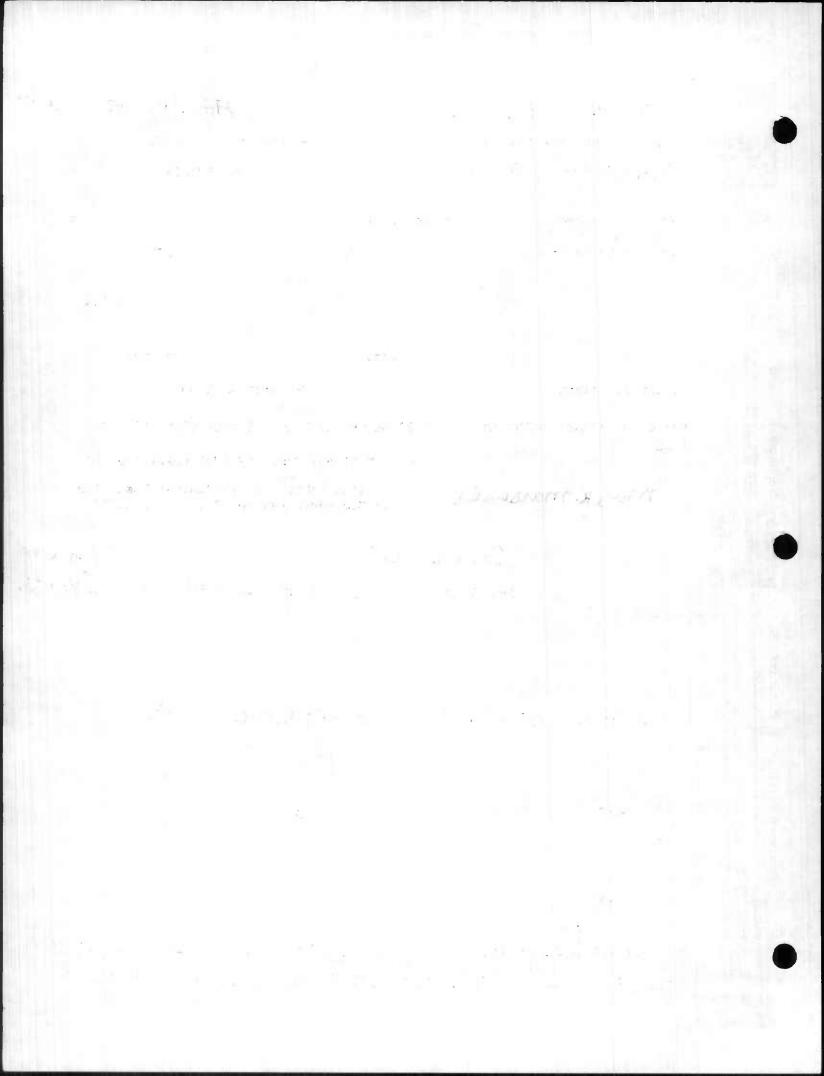
Funeral

Director

JUNF

5. Social Security Number

10a. State



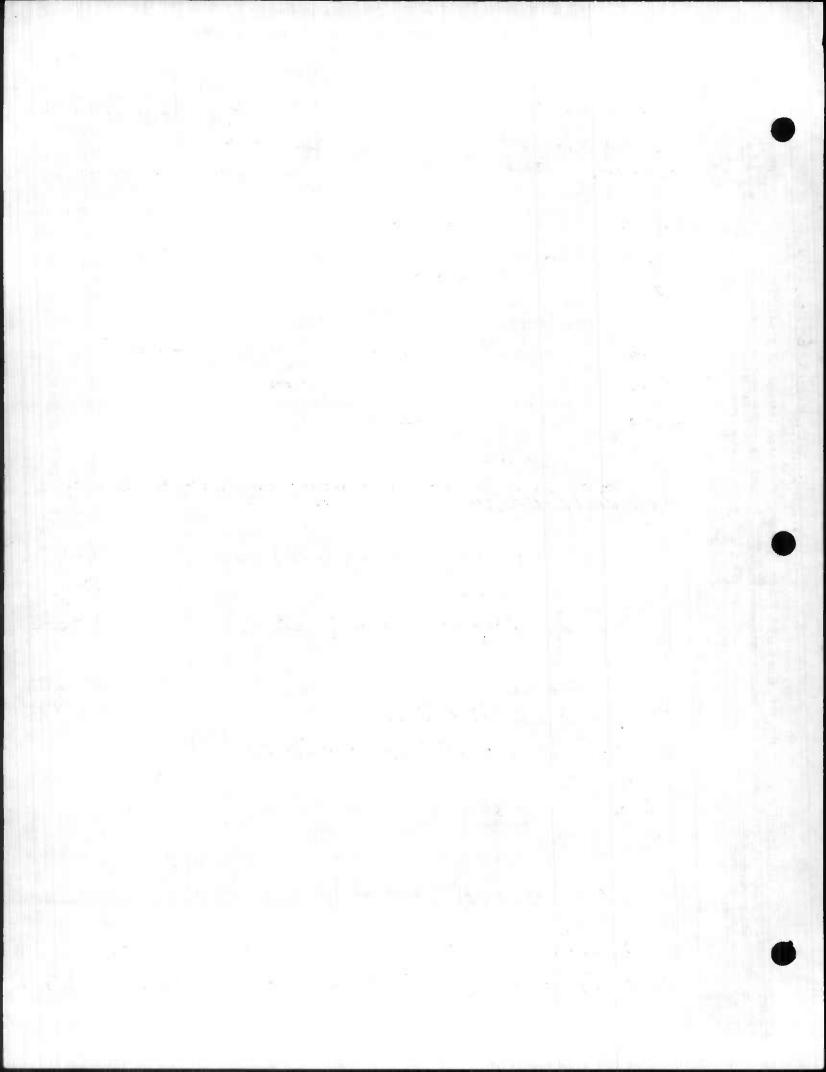
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Frank Benczkowski /Medical 4a Facility Name (If not institution, give street and number) City, Town, or Location 4c. County of Death Examiner to Spita nai 5. Social Security Number 7. Age (In yrs. last birthday) Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Yrs. 94 28,1905 214-66-4577 Director unknown Usual Rasidance of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Nesical Examiner mast be notified at Yes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Grown as Frank Benczkowsk 21215 U.S.A. 2606 Woodland Avenue Funeral filed within 72 hours aftar deeth 12. Was Decedent Ever in U.S. Armed Forces? UNKNOWN 1 ☐ Yes . 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married n and Mental Hygiena. is merked other than "natural", or 1 Ves 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced unknown 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Pages 1 end 2 should be unknown unknown 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if Item 27 is any Injury or other train unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetlon 5 XOther (Specify) in state 21. Signature of Funeral Service Licensee Bonald S. Wade, Director State Anatomy Board, 655 W.

Baltimore, MD 21201

23a. Part1. Enter the disease, or combications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, sheck, or heart failure. List only one cause on each line. 22. Name and Address of Facility 655 W. Baltimore St. Approximate interval Batween Onset and Death **Physician** /Medical Immediate Causa (Final Multisystem Organ Failure
Dudto (or as a consequence of) disease or condition resulting in death) Examiner Examiner physician end the burief-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last Division of Vital Records, P.O. Box 68760, Myocardia Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Aunknown Vascular Disease þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Failure, Acute Respiratory Distress s certificate has b director, page 2 s 25. Was casa rafarrad to medical examiner? 2 No or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after deeth. To the Funeral Director: At completaly filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, ferm, streat, factory, office building, etc. (Specify) 4 Homleide t 🖄 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name end address of parson who completed causa of daath (Item 23a) (Type, Print) 2701 Wat Belvedere Ave. Ballimore, MD 21215 ,mo Ewing, MO Year) 1999

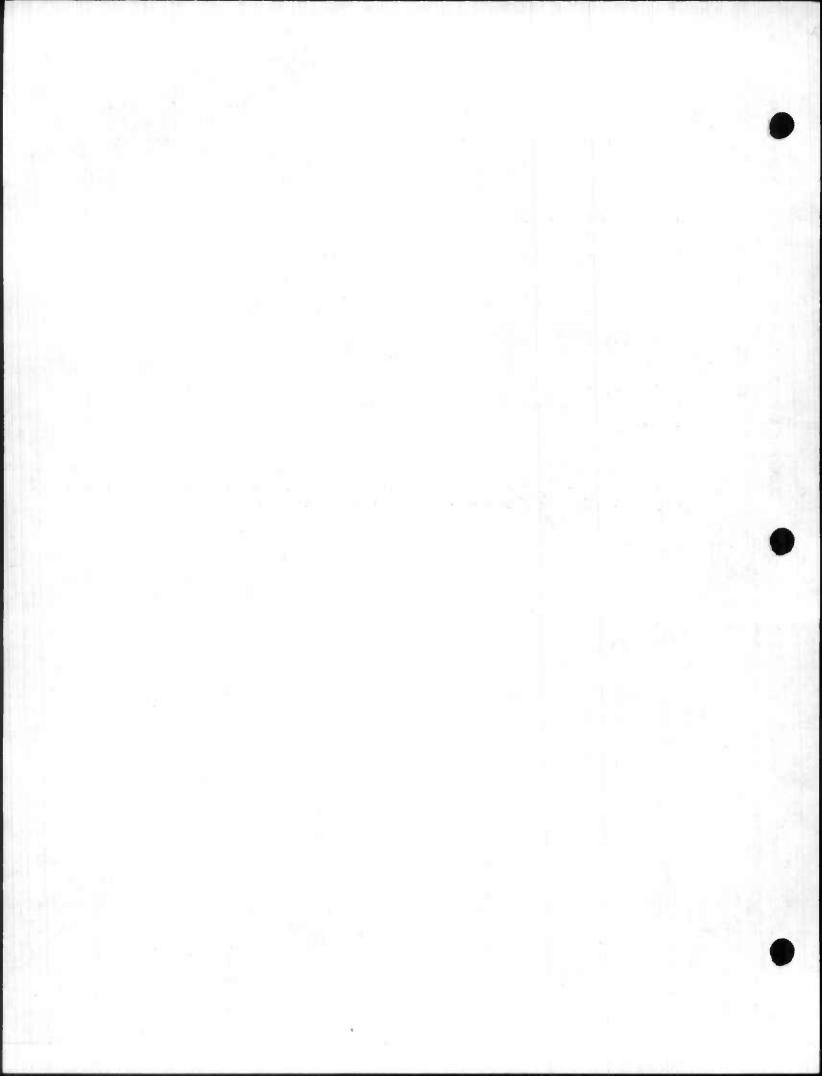
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Harris | Service of the Servic | State of Ivial | | ertificate of | | | Reg. No. 9 | 13221 | | | | |
|---|--|---|-------------------------------------|--|---|--|--|---|--|--|--|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last | | | 2. Date of De Month April | Dey Yes | | | | | | | |
| Examiner | 4e Facility Neme (If not Institution, give | street end number) | | 4 | lb. City, Town, or Lo | ocation of Death | eath | | | | | |
| | Anne Arundel Med | ical Center | |) If Under 1 Yeer | Annapoli | | Anne A | | | | | |
| Funeral Director | 5. Sociel Security Number 6. S 214-38-0200 Usuel Residence of Decedent | ex □ M 2ĂF | Hours Min. | 8. Dete of Bir (Month, Da March | y, Year) 1909 Ma | Birthplaca (State or Foreign Country) ryland | | | | | | |
| in g m | 10a. Stete 10b. County 10c. City, Town or Location | | | | | | 10d. | | | | | |
| with the Marylan a or 28e-f show be notified at Director | Maryland Anne Ar | undel | Annapoli | S | | | | 1 Yes 2 No | | | | |
| vith the Ma t or 28e-f a be notified Director | 10e. Street and Number | 1 | | 10f. Zip Code | | | 10g. Citizen of What | Country? | | | | |
| 238 mm | 8 N. Homeland Ave | nue | | 2140 | 1 | | U.S.A. | | | | | |
| 0020 hours after death w uvel', or litera 23e al Examiner must. d by Funeral | 11. Maritel Stetus 1 🕅 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: | er in U,S. 13. | Wes Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☒ No | ispanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | 14. Race - A Bleck, W Specify: | merican Indien, Thite, etc. white | | | | |
| Maryland 21215-0020 of 2 should be flad within 72 hours at the and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Example To Be Completed by F | 15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12) | lucation de completed) College (1-4or 5+) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of work) life. DO NOT use retired) | | | 16b. Kind of Busine | | | | | |
| D High | 17. Father's Neme (First, Middle, Last) | 4 | Le | teacher 18. Mother's Nem | | | me (First, Middle, Maiden Surneme) | | | | | |
| ylanc wid be fi Mental P Mental P Mental P To Be | William G. Brewer | | | | Antoinet | te Morr | is | | | | | |
| Canada L | 19e. Informent's Neme/Reletionship (7 | Type, Print) | 19b. Meil | ling Address (Street | and Number or Run | al Route Numb | Number, City or Town, State, Zip Code) | | | | | |
| C 2 00 M | unknown | | unkn | | | | | | | | | |
| Baltimore, | 20e. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ 4 ☒ Donetion 5 □ Other (Specify | Removel from Stete | 20b. Plece of Disp cametery, cre | osition (Name of emetory or other plea | (e) | Date | 20c. Location - City | or Town, State | | | | |
| Balt Depart Import any inj once. | 21. Signification of Funeral Service Licensee Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | | | | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Finel disease or condition resulting In deeth) | Cang | es to (or as e conse | e Hen | of Fau | lure | 11651, | Approximate Interval Between Onset and Death | | | | |
| and transit | Sequentially list conditions, | b | e to (or es e conse | equence of): | relation | | | Imonth | | | | |
| DX 68760, certificate be executed nding physician and use as the burial-transit n/Medical Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last | C. Due | e to (or as e conse | quence of): | | | | | | | | |
| death certification of for use a | | | | | | | | | | | | |
| P.O. hat the do by the detached | Pert II, Other eignificant conditions co | entribution to death but n | oot resulting in the | underlying cause giv | en in Pert I. | | | ute to the cause of death? Probably 4 Unknown | | | | |
| aw requir | Appertens | ion C | rebr | wasce | Der | perfo | ormed? | bb. Were eutopsy findings eveilable prior to completion of cause of death? | | | | |
| Vital R Idean: The certificate h irector, page | OF Was one referred to medical | Lei | | | | | Yes 2 10 | 1 Yes 2 No | | | | |
| of Vital Re Physician: The it ribis certificate he rel director, page | 25. Wes cese referred to medical examiner? | Hospitel: | 2 DER/Outpatie | ent 3 DOA Oth | er: | | one) dence 6 Other (5 | Secretary . | | | | |
| Ming Phy. After thi funeral | 27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Dey Yo | 28b. Time o | | рөспу) | | | | | | | |
| 5 8 8 E | 3 Suicide 6 Could not be determined | 28e. Plece of Injury building, etc. (5 | - At home, ferm, si Specify) | treet, factory, office | | | 8f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To the Hospital within 24 hours. To the Funeral completely filled Medical Co | (Check only 2 Medical Exam | valcian: To the best of m iner; On the basis of ex- end menner steled | aminetion end/or Ir | th occurred et the time time time time. The time time time to the time time time time time time time tim | ne, date end place, pinion, death occurr | and due to the red at the time, | cause(s) and manne date end plece, and | r as stated. due to the cause(s) | | | | |
| with Com | 29b. Signature and other of certifier | Dereng | · Mi | 29c. Licens | 6 4 | 88 | 29d. Datersigned (N | onth, Day, Year) | | | | |
| | 30. Name and address of person who of | hrens, M | (Item 23a) (Type | - // // | Ave Ste | (50,1 | Annapol | Cul , zi | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) ADD 9 2, 1999 | 32. Registrer's | | Some V. | (| | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien € . ○ Certificate of Death Reg. No 1. Decedent's Name (First, Midgla, Last) 2. Date of Death 3. Time of Death **Physician** 0 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7. Age (In frs. last birthdey) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex place (State or Foreign **Funeral** Days 10XM 2□ F 9 Director the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits marked other than "natural", or items 23a or 28a-f show imatic event, the Maxical Examiner must be notified at 1 Yes 2 No Director Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Oint 21222 0 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Raca - American Indian, Black, White, atc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify by 3 Widowed 4 □ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event pages. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hessandro 2 19a. Informant's Name/Raletionship (Type, Print) or Rurel Route Number, City or Town, State, Zip Code, 19b. Mailing Address (Street and Number 20a. Mathod of Disposition

1 Serial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State tery, crematory or other place) 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee Evans Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespect, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final nounonia disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Lospina The law requires that the death certificate be asscuted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury thal initieled events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or es e consequence of) 98 attending 9SN for signed by the a Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3屋 Probably 4 ☐ Unknown py 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen has N page 1 TYes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Chack only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ inpatient 10 2 ER/Outpatient 3□ DOA within 24 hours efter death. To the Funeral Director: After this 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Panding investigation 1 Naturat 1 Yes 2 - No 2 Accidant 6 Could not be datamined 3 Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homlcide Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical completaly

State Registrar 29b. Signatura

DHMH 16 Rev 6/95

Maryland 21215-0020

Baltimore,

Box 68760.

Records, P.O.

Division of Vital

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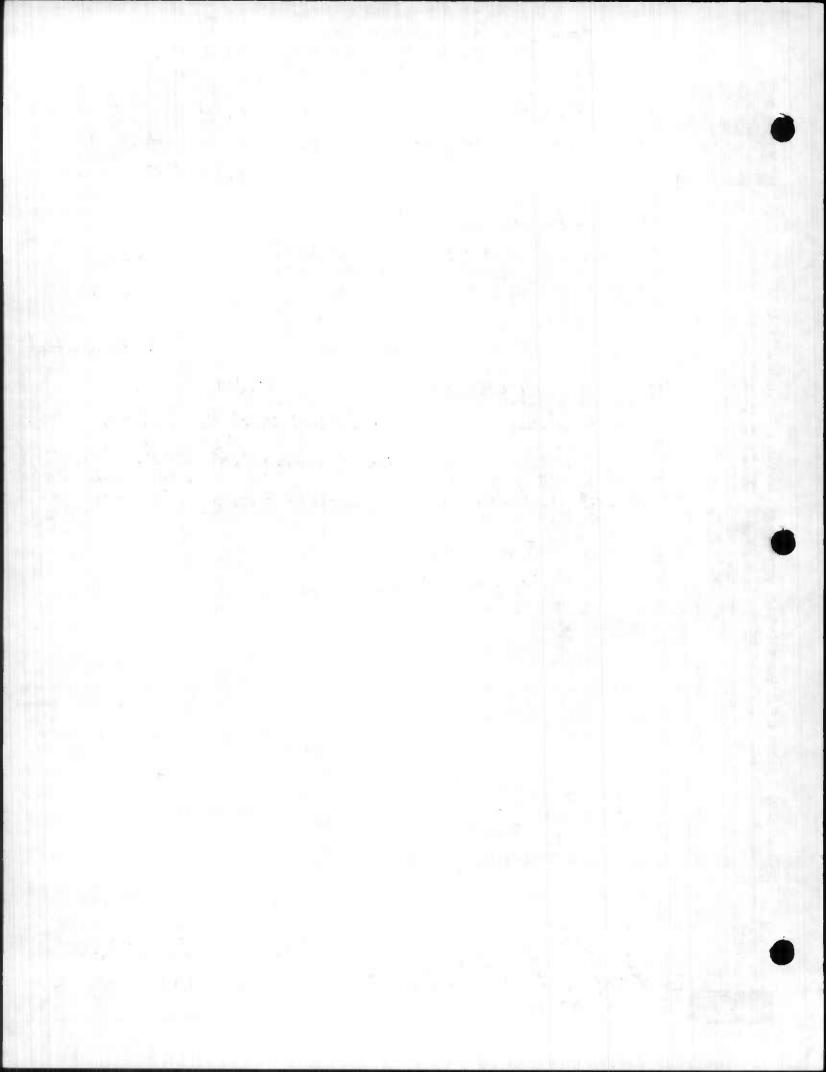
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A rson who complated causa of daath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 2 2 tallston Mari 2112 32. Registrar's Signature . per

29c. License number

29d. Date signed (Month, Day, Year)

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DHMH 16 Rev 6/95

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To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Box 68760,

Division of Vital Records, P.

Attending Physician:

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State Registrar

31. Dete filed (Month, Dey, Yeer)

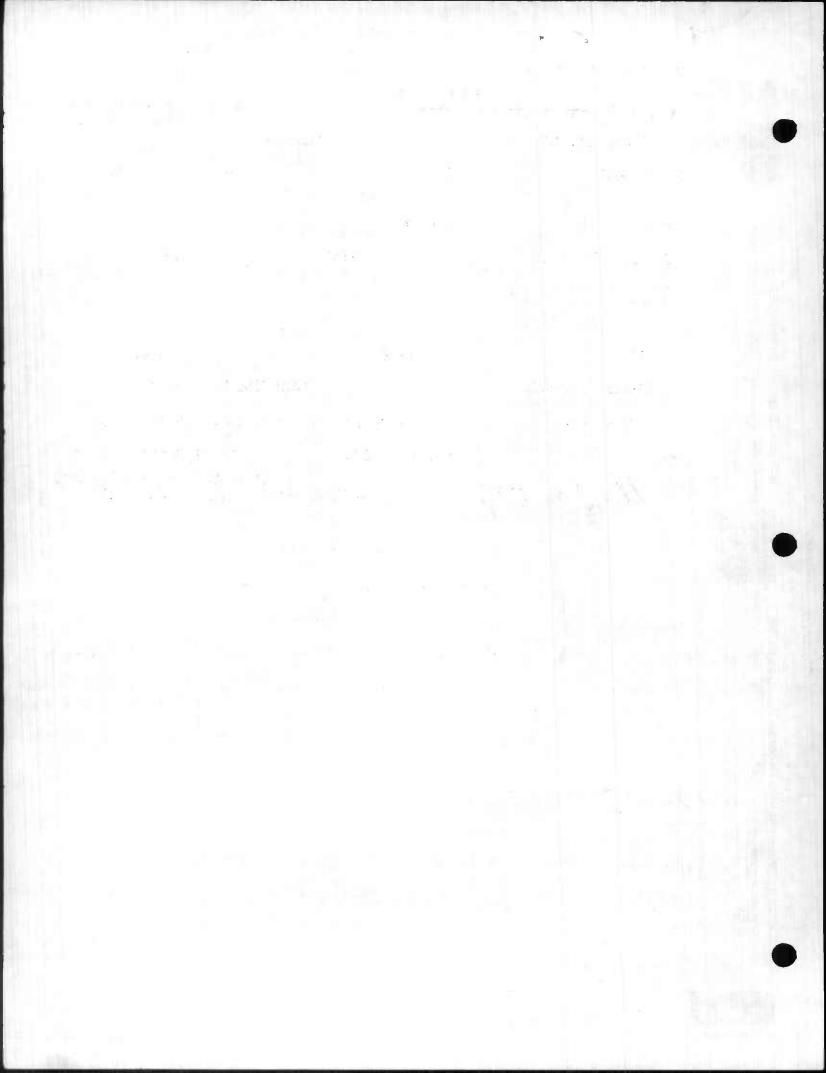
32. Registrer's Signeture

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

DESAIK. GIlsouth charles streak

APR 2 2 1999

Balhmore my 21230



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| 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility ESTEP BROTHERS FUNE 1300 EUTAW PLACE BALTIMORE, MARYLAN | | | | | | | | | | | |
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2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner steted. edical 29e. Certifier (Check only one)

Division of Vital Records, To the Hospital or Attending Physician: The lew requires twithin 24 hours after death.

To the Funeral Director: After this certificate hes been signs completely filled in by the funerel director, page 2 should be

> State Registrar

DHMH 16 Rev 6/95

ted cause of death (Item 23s) (Type, Print) 30. Name and address of person who come

1 in

APR 22 1999

29b. Signeture end title of certified

29c. License number

D30951

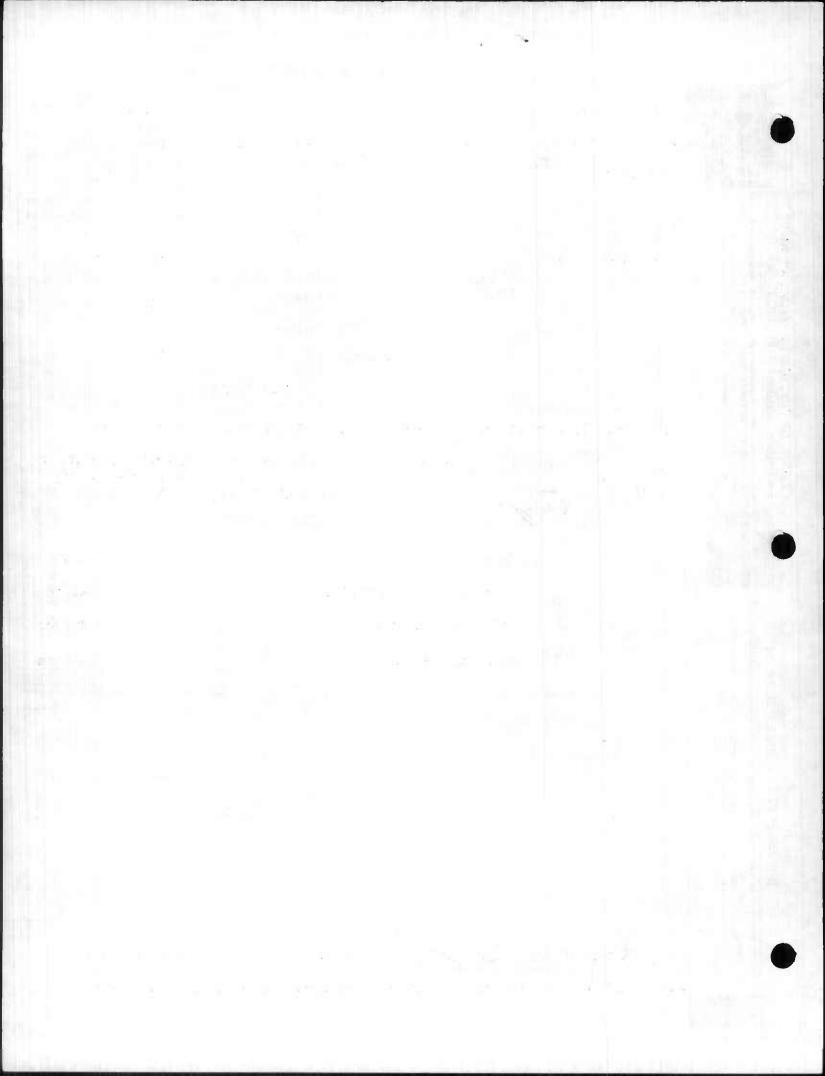
29d. Date signed (Month, Day, Year)

HOME P.A.

April 19, 1999

ANGELO LUCCO, M.D., VA Maryland Health Care System, Perry Point, MD 21902 31. Dete filed (Month, Day, Year)

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth **Physician** Marcella /Medicai 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth Examiner Baltimore Maryland 5. Sociel Security Number Baltimore 6 If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, 9. Birthplece (Stete or Foreign **Funeral** Month, Dey, Year)

JULY 16, 1954 Months Deys 1□M 20 F 44 Yrs. 214-62-6176 Usuel Residence of Decedent Director with the Maryland 10a. Stete 10b. County 10d. Inside City Limits 28a-f show rai', or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? TAMBURG STREET USA. permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Deportment of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23, any injury or other traumatic event, in the digit is the most main Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No rr Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11+HGRADE UNEMPLOYED 17. Fether's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumeme) Be REMUS 0 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1003 CREEK STREET, BALTIMORE, MD. 21230 e of Disposition (Neme of Dete 20c. Location - City of Town, State MONA LASANE 20e. Method of Disposition

10 Buriel 2 Cremation 3 Removel from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 5 ☐ Other (Specify) 04-27-996WINGS HILLS, MD. 4 Donation N JR. FUNERAL HOME 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) edema Examiner Physician/Medical Examiner Doxemia sician end buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Box 68760. ardiac the 88 ardiomyopathy for use P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? page 2 s 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpetient 3 DOA Certification: To this 27. Menger of Deeth 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 2 Accident 5 Pending investigation 1 Tyes 2 No 24 hours efter death. Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29e. Certifier Medicai completely (Check only one) within 2 29b. Signeture and 29c. License number 29d. Dete signed (Month, Dey, Year) s of person who completed cause of death (Item 23a) (Type, Print) 30. Name er Baltimore, MD 21201

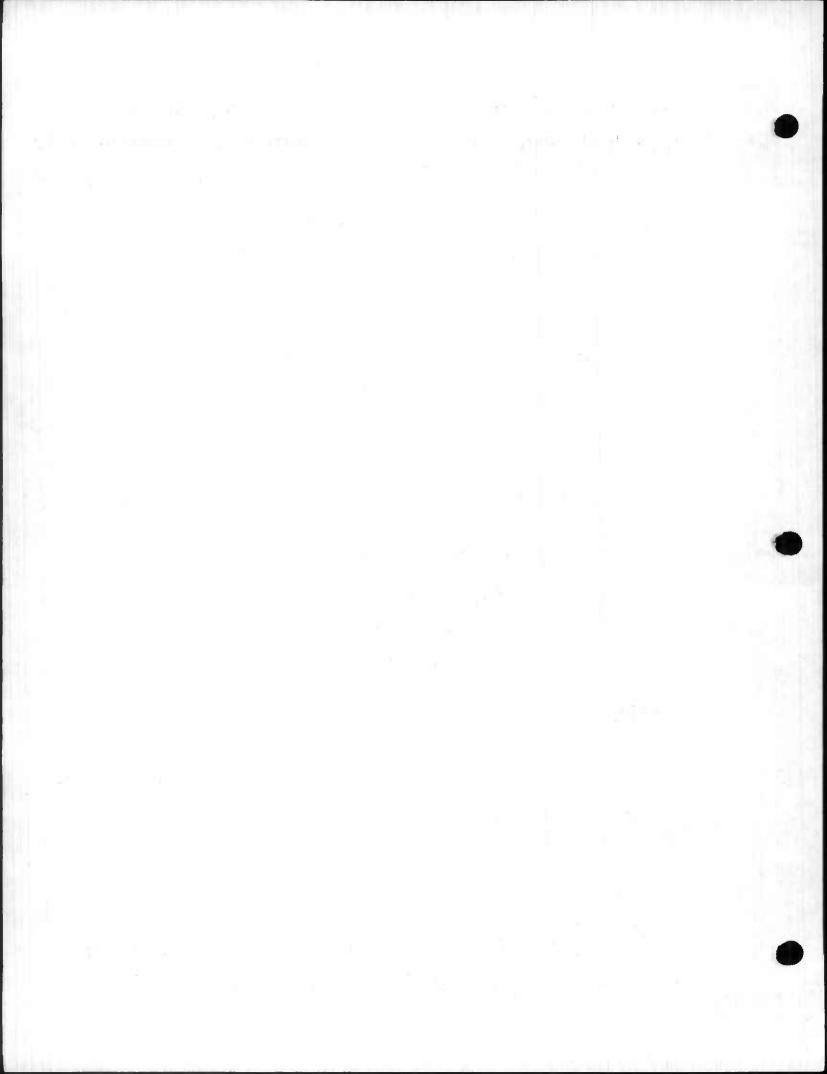
State DHMH 16 Rev 6/95

Registrar

APR 22 1000

31. Dete filed (Month, Day,

22. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Vear MARY ELLEN BAILEYS 11:30 AM 1999 APRIL 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death SHEHAN CENTER

7. Age (In yrs. last birthday)
Months Days TIMONIUM Nunder 24 Hrs. 8. D Hours Min. STELLA MARIS / CARDINAL BALTIMORE Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10M 20F 81 207-05-1524 PA Usuel Rasidence of Decedent 10c. City, Town or Location 10e Stete 10h County 10d Inside City Limits 1 Yes 2 70 COCKEYSVILLE MD BALTIMODE 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A. 21030 2 CITESHAM Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Maritei Status Bleck, Whita, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced WHITE 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BETHESDA Elemantary/Secondary (0-12) Coilege (1-4or 5+) U.S. NAVAL HOSPITAL SUPPEVISOR 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) MARY A. PATRICK NORTON DEAN 19a. Informent's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) CT. COCKETSVILLE, MD. 2105C DANIEL R. BALLETS, JR., SON 21030 2 CHESHAM 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State APPRIL 21, WASITINGTON, D.C. OUVED CEMETERY 1999 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility SVANS CHAPEL OF CHIMES 23a. Part1. Enter the disease, or contribications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert feilure. List only the causa on each line. TIMONIUM, MD. 21093 Approximata Interval Between Onset end Deeth dementia 3YRS Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initieted evants resulting in death) Last Dua to (or as a consequanca of): Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f

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Hygiene. other than *natura ent, the Medical E

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Baltimore, Maryland 21215-0020

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Certification: To

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that the death certificate be executed P.O. Box 68760. is certificata hes l director, page 2 s

Division of Vital Records. Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica stely filled in by the funeral director, To the Hospital or within 24 hours aff To the Funerel Di completely filled in

State Registrar auch

5 Pending Invastigation

6 Could not be datarmined

1 Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier

030641

28a. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify)

1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the causa(s) and mannar stated. 29d. Date signed (Month, Day, Year) April 1915 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Suite 308 821 N. Estaw St 13altimox 21201 31. Date filed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Dav Month Year G. NETTLE BORIG APRIL 1999 1:25 PM 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death GENESIS ELDECARE PERING PICMY. 5. Social Security Number 6. Sex 7. Age (In vis. last birthday) CTP. PARKVILLE BALTIMORE Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) 24 Hrs. Months Min. Davs 1 M 2 F Hours MD 17,1910 212-32-5329 APRIL Usual Rasidence of Deceder 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYPS 2 THO MD BROOKLYN 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 4711 U.S.A. CITCHIE HIGHWAY 21225 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Meritel Stetus 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER AT HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) REVLING IDA EUZABETH KOFFENBERGED LEONARD 19a. Informant's Name/Raletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21140 CAROL E. DER, DAUGITTER 211 GEISDALE HILL RIVA , MD. 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data APRIL 20 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □Other (Specify) 1999 ROSEDALE, MD GARDENS OF FAITH 22. Name and Address of Facility EVANS CHAPELOFMEMORIES 21. Signature of Funeral 36 ies Ticonspe All Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. PARKVILLE MO. 21234 Approximata Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Dementla Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Disaase or injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was an autopsy 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital Attending Physician: death. after death Director: / 6 To the Hospitat or within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

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Funeral

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Physician /Medical

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this funeral

After

altimore, Maryland 21215-0020

Registrar

DHMH 16 Rev 6/95

10

State

MIRZA

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

DR. ZIAD



3007 E NORTHERN

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

29c. License number

0 66049

PKWY

29d. Dete signed (Month, Day, Year)

BALTMORE, MD.

printer that the terminal and the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Yaar Charles H. Birely 7:45 Am 18,1999 April 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Perring Parkway Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yeer 5. Social Security Number 8. Sax Birthplace (State or Foreign Country) Months 1⊠M 2□ F Devs 213-03-6454 April 12, 1909 maryland Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Avenue 21234 U.S.A. 3120 California 12. Was Decedant Ever in U,S. Armed Forcas? 1 ⊠Yas 2 □ No If Yas, Giva 14. Rece - Amarican Indian, Black, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Merital Stetus 1 Nevar Merried 2 Married 1□ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Detes: \ 94-1945 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Service States 10 Auto Mechanic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles H. Birely Alice H. Hardesty 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3120 california Ave. Parkville, mo 21234 Margaret M. Birely-wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 MBurlal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) April 21, Parkville, MD 1999 Parkwood Cemeter 21. Signature of Funeral Service Licensage 22. Nama and Address of Facility of memories Evans chapel 8500 Harford 23 Paw Krille, MD 21234 Pand Entar tha disaasa, or complications that causad the dieth. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona ceusa on aech lina. Approximata Intarval Batween Onset and Death Immediate Ceuse (Finel disaasa or condition rasulting in daath) Bua,to (or as a consequence of) rullalion ial Sequentially list conditions, if eny, leading to immadiata causa. Entar Undarlying Ceusa (Diseasa or Injury that initieted events resulting in daath) Last Dua to (or as a consequence ot) Dua to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy 1 Yas 2 No 1 Yes 2 No 25. Was casa retarred to medical axaminar? 26. Pleca of Death (Chack only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Yas 2 No 27, Mannus of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Chlatural 5 Panding Invastigation 1 Yes 2 No T Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To tha best of my knowledga, death occurred at the time, dete end piece, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of examination end/or invastigation, in my opinion, deeth occurred et tha time, data and place, and due to the causa(s) and mannar stated.

29c. Licansa number

/Medical Examiner The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician:

attending physician and for use as the burial-transit signed by the a should I has i I director, page 2 this Affer death. Director: A 5 To the Hospital or A within 24 hours effar To the Funeral Directompletely filled in by

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

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Certification: To

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Hygiane. yther than "natural", or frems 23a or 28a-f show ent, the Medical Examiner must be notified at

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Demmit Pages 1 and 2 should be file.
Department of Heelih and Mental Hydi
any hijury or other.

Physician

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

31. Date filad (Month, Day, Year)

29a. Certifier

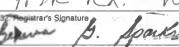
(Check only one)

29b. Signatura and titla of certifier

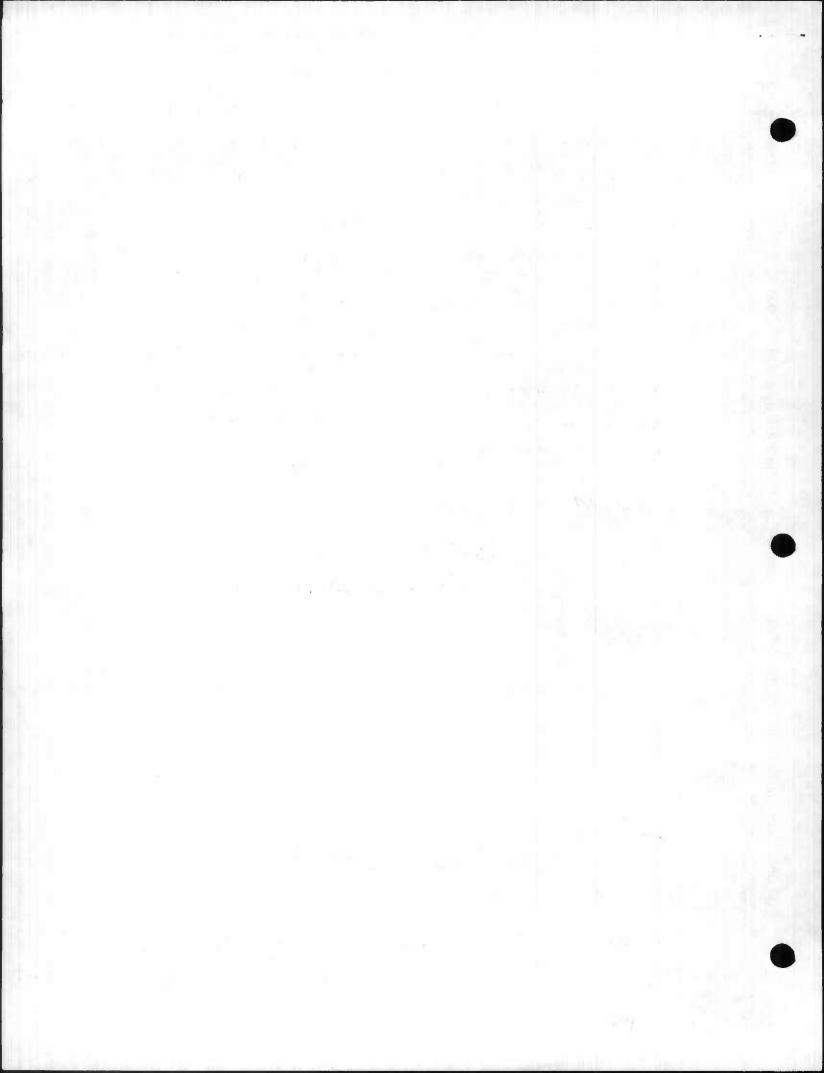
38

APR 2 2 1999

30. Name and eddress of person who completed cause of deeth (Item 23q) (Type, Print)



29d. Date signed (Month, Day, Year)

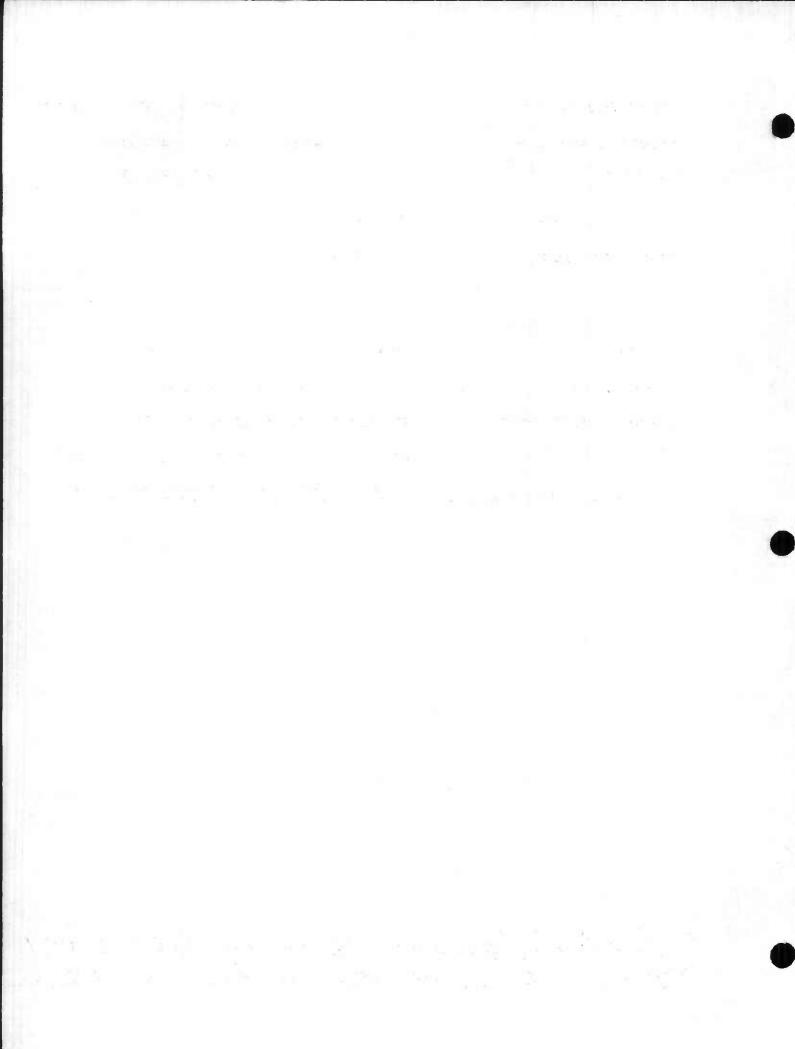


State of Maryland / Department of Health and Mental Hygiene

| | | | | | , | | tificate of | Death | | g. No. | 106 | | | | |
|------------|---|---------------------|--|--|---|----------------------------------|--|---|---|----------------------------------|-------------------------------------|---|--|------------|-------------|
| | Dhusisi | | 1. Decedent's Neme (First, Mide | dle, Last) | | | | | 2. Dete of Death Month | Dey | Year 3. | Time of Death | | | |
| | Physici /Medi | | GENEVIEVE BARANOWSKI | | | | | | APRIL 12, 19 | | | 9:40PM | | | |
| À | Examir | | 4e. Fecility Neme (If not institution | on, give street end nur | m <i>ber)</i> | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Deeth | | | | |
| | | | FRIENDS NURSI | NG HOME | | | | SANDY SPE | | | GOMERY | | | | |
| | Funeral Director | | 5. Sociel Security Number 189–30–9156 | 6. Sex 1□ M 2ÅF | 7. Age (In yrs. 79 | | if Under 1 Year Months Deys | | 8. Date of Birth (Month, Day, 12/28/1 | Year) 919 | 9. Birthplace Country) PA | State or Foreign | | | |
| | hend wo | | Usuel Rasidence of Decedent 10e. Stete 10b. Count | у | 10c. City | y, Town or Lo | cation | | | | 10d. In | side City Limits | | | |
| | the Maryler 28e-f show | to | MD HO | WARD | | HIGH | ILAND | | | | 1 | ¥Yes 2 ☐ No | | | |
| | r 286 | irec | 10e. Street and Number | | | | 10f. Zip Code | | 10 | g. Citizen of W | /het Country? | | | | |
| | h with | ai D | 13425 ALLNUT | LANE | | | 20777 | | | | U.S.A. | | | | |
| 21215-0020 | deat | ner | 11. Marital Status | 12. Was Dece | edent Ever In U, | ,S. 13. | Was Decedent of I | Hispanic Orlgin? (Sp | pecify Yes or No- | | - American In- | dian, | | | |
| | filed within 72 hours efter death with the Maryland Hyglene. ther than "natural", or flerna 23a or 28e-f show ont, the Medical Examiner must be notified at | by Funeral Director | 1 ☐ Never Merried 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce | If Yes Gi | 2⊠ No ∕e | | 1 ☐ Yes 2 ☐ No | | ispanic Orlgin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.) | | | | | | |
| 5-0 | "natur | ted | 15. Decede | nt's Educetion est grade completed) | eted) 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | | | pation | kina 1 | 16b. Kind of Business/Industry | | | | | |
| 21 | ithin Ben | Completed | Eiementery/Secondary (0-12) | | 1-4or 5+) | | | d) | (III) | | WN HOME | | | | |
| | filed with Hygiene. ther ther | | 12 | | | HOMEM | IAKER | 1 14 11 25 25 11 6 | | | | | | | |
| and | d off | Be | 17. Fether's Neme (First, Middle | | | | | | ne (First, Middle, Meiden Sumen | | ne) | | | | |
| Ž | 2 should be and Mental is marked o | 10 | FRANK ADAMSKI | | | 405 84-10- | - A dd (O | | INE PRZYG | | | | | | |
| Maryland | and 2 si eeith an n 27 is r | | 19e. Informant's Neme/Reletion GERALDINE GREE | | | | | t end Number or Rus LANE HIGH | | | Stete, Zip Gode | 9) | | | |
| Baitimore, | 1 and 1 Heeith em 27 | | 20a. Method of Disposition | ity briedili br | 20b. P | lece of Dispo | sition (Name of | | | | City or Town, S | Stete | | | |
| | permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Manance. | | Buriel 2 Cramation | | Stete | | netory or other pie CEMETERY | | 1/17/99 N | | | | | | |
| | permit. Page Department of Important: If any Injury or ance. | | 4 Donetion 5 Other (| | | | . Neme and Addre | | 7 2 7 7 3 3 | | | -, | | | |
| Ba | Depar Impor any Ir | | N 400 | mars! | -00 | SI | ERLING-A | ASHTON-SCH | | | | | | | |
| | Physician /Medical Examiner | ler | 23a. Part1. Enter the diseese, shock, or heart feliure. Lis Immediete Ceusa (Final diseese or condition resulting in deeth) | e. | | | - | ng, such es cerdiec EU HO A DE | , | | Inter | Toximate val Between et and Death DAYS | | | |
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| | e death the atte | | Pert li. Other algolificant condit | lona contributing to de | eath but not resu | uiting in the u | derlying ceuse gi | ven in Pert I. | 23b. Dld tol | bacco use con | tribute to the | cause of death? | | | |
| P.0 | as that the de igned by the be detached | | by | | | REHOTE (| CERTI | BRAC | Th | 201B | 915 | 1 □ Ye | s 212 No | 3 Probably | 4 🗌 Unknown |
| Records, | requir | | | | | 71-0 | | | | 24a. Wes an | eutopsy ned? | avellable | utopsy findings e prior to ion of ceuse ? | | |
| æ | The law ata has b page 2 s | E O | | | | | | | 1□ Ye | s 2 No | | 2□ No | | | |
| Vital | | Bec | 25. Wes cese referred to medic | al | | | | 26. Piece of Dea | th (Check only one | | | | | | |
| > | Physician: this certific ral director, | To B | exeminer? 1 ☐ Yas 2 ☑ No | Hospital: | npatient 2 | ER/Outpatien | t 3 DOA Ott | | ome 5□Resider | | er (Specify) | | | | |
| ion of | Attending Ph ir death. ector: After th by the funeral | | 27. Manner of Deeth 1 Naturei 5 Pend 2 Accident invest | ing (Mont | of Injury th, Day Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | ry at | 28d. Describe ho | | | | | | |
| Division | al or Atte s after de al Directo ed in by th | Certification: | 3 Sulcide 6 Couid deten | mined 286. Plece | of Injury - At ho ng, etc. (Specify | ome, ferm, str | aat, fectory, office | | 28f. Location (Str. City or Town, | | er or Rural Rou | te Number, | | | |
| | To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edical | (Check only 2 Medica one) | 1 | best of my know asis of examinet her stated. | wladga, daath tion end/or inv | occurred et the time time time time time time time tim | me, dete end plece, opinion, death occur | and dua to tha ca red et the time, de | usa(s) and ma te end piace, e | nnar as stated. and due to the d | ceuse(s) | | | |
| | To the within 7 To the comple | | Signature end title of certific | KIL | y lides | 16 | 29c. Licens | | | A | (Month, Day, | and the same | | | |
| 1— | | | PONALZ | who completed ceus | e of feeth (Item | 23e) (Type, | Print) | 4000 | £T108 | 04 | 404 | TP 2083 | | | |

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Month Day **Physician** April 16,1999 MARY ELIZABETH 12:34 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORF

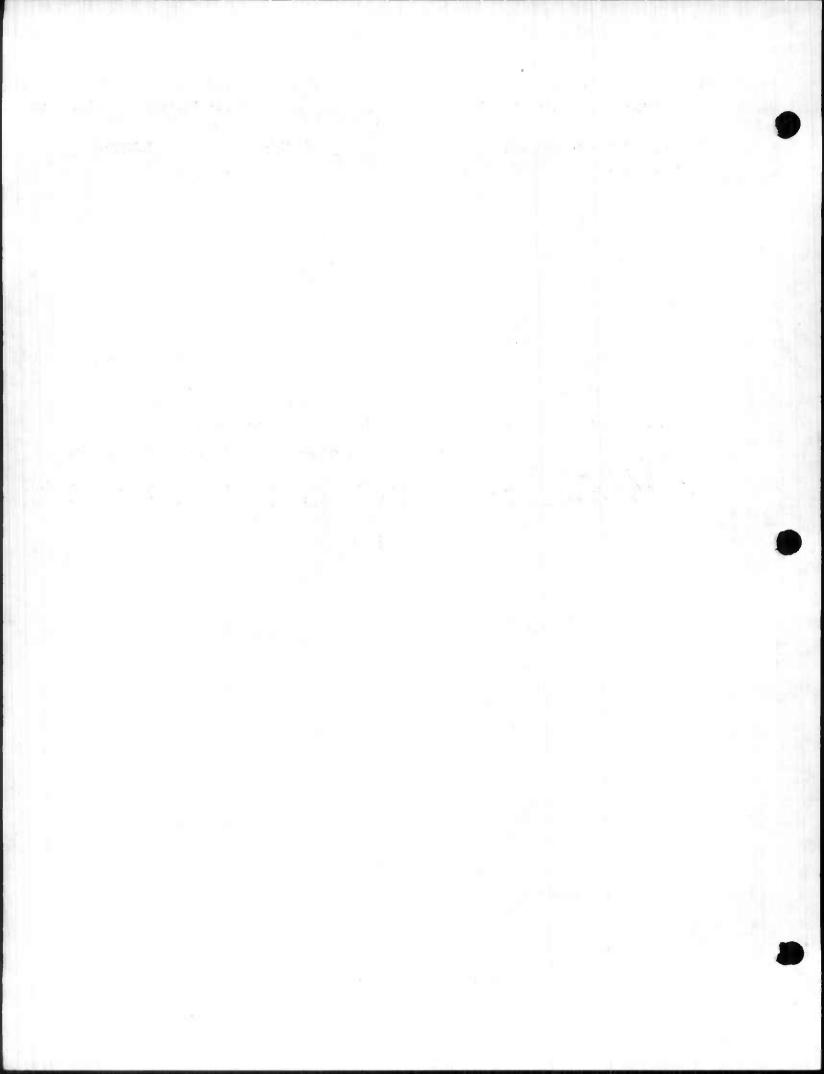
9. Birthplace (State or Foreign Country) RIVERVIEW CARE CENTER If Under 24 Hrs 7. Age (In yrs. lest birthday) If Undar 1 Year 8. Data of Birth (Month, Dey, Yeer) Funeral، Months Days Min 1□M 20 F Yrs. 215-05-4508 Director 6/16/1910 Maryland Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show must be notified at XXYes 2□No Director Baltimore 10f. Zip Code MD N/A 10e. Street and Number 10g. Citizen of What Country? 8 238 159 N. Steeper Funeral St 21224 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Barne 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 b 1 ☐ Yes 2 ☐No Specify: þ SpecifiWhite 3 Widowed 4 ☐ Divorced natural. Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) N/A 6th Grade Housewife 18. Mother's Name (First, Middle, Maiden Surneme) Saltimore, Maryland 17. Fathar's Nama (First, Middle, Last) Be h and Mental I 2 marked c Pages 1 and 2 should John Asmussen Theresa Pfeister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if them 27 is any injury or other trax once. 2004 Ormand Road Dundalk, MD 21222
ce of Disposition (Name of Data 20c. Location - City or Town, Stata Mr. Ronald Brown 20b. Place of Disposition (Neme of cempter), crematory or other place)
Most Holy Redeemer Cem 4/19/99 Balto., MD 20a. Method of Disposition **Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fungal Serves Licensee 22. Name and Address of Facility
Moran Ashton Dabrowski Funeral Home, Inc. 3000 E. Baltimore St. Baltimore, MD21224 23a Party Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or hearf failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical mediate Causa (Final disaasa or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated avents rasulting in death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the undarfying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Ø Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? certificate has 1 ☐ Yes 2 1 No 1 Yes 2 No or Attending Physician: 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 determined 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner as stated.

Medicel Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and menner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Dey, Yeef) 29b. Signature and title of certifier 29c. Licansa number D 30661 Duraker 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SIREESH TRIPURANENT Abe, 1 Eastern Ballimore, Hd - 21221

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)
APR 2 2 1999

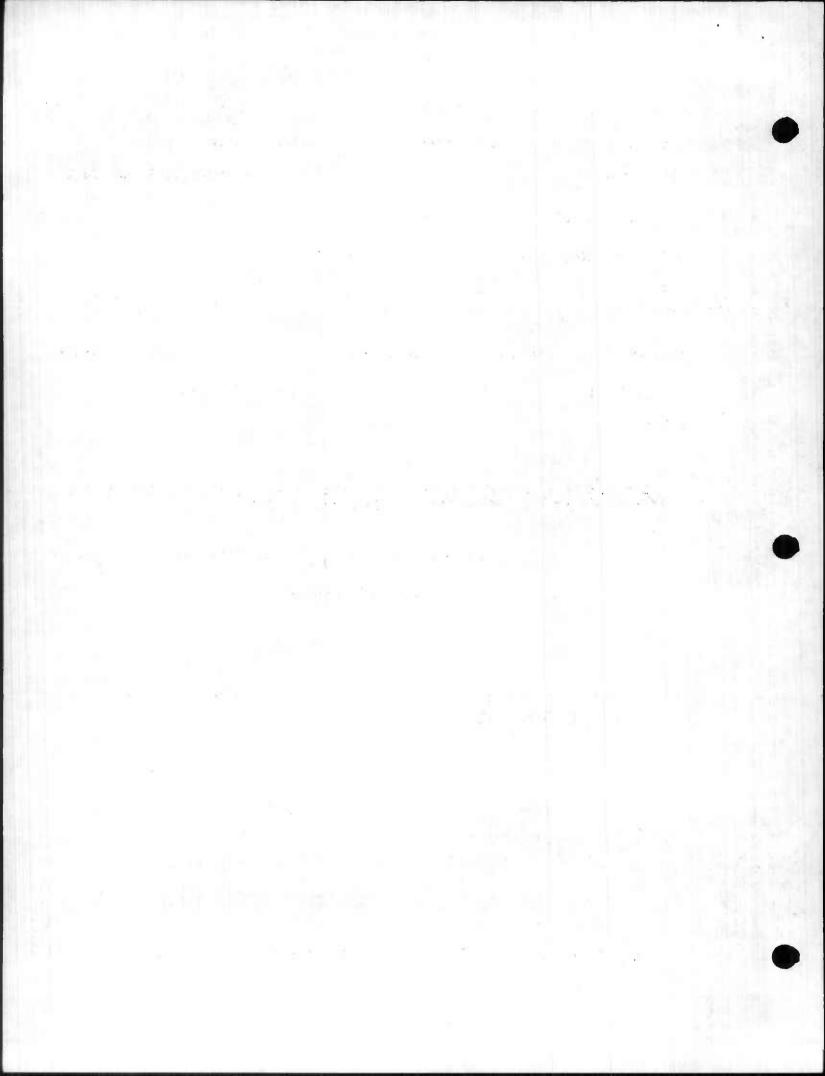
32. Registrar's Signature



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:20 PM Constance mary 1999 Apri /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Agnes Nursing & Rehab Center Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** 1□M 2⊠F Yrs. 91 131-01-4801 Director Nov. 27, 1907 New York Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Howard Ellicott City Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with r than "natural", or items 23s or the Medical Examiner must be 3000 North Ridge Road 21043 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "naturel, or items 23s any injury or other traumatic event, the Medical Examines mast of DRGs. 14. Raca - American Indian, Bleck, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Navar Married 2 Married 1 ☐ Yas 2X No If Yes, Give Yaar or Dates: 1 ☐ Yes 2X No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) unknown unknown secretary Federal Government 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Joseph Casale Beatrice unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) unknown unknown 20b. Place of Disposition (Name of camatary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Water Birector State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201 Int. Enter the disease or complications that causad the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical DEMENTIA Examiner Examiner An tron itis physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pothy noin by 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only ona) 3E No Other: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hour. the Funeral Direction JET Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner statad. To the Hospi within 24 hou To the Funer completely fil edical 29a. Certifier 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3/5 CERTIFOR DR 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 2 % 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 2:27 AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) MHIMWRE N/A a 00 0 If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociei Security Number 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) Deys 218-22-383 Yrs Desember 1 1428 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A 10g. Citizen of Whet Country? 10e. Street end Number 456 ST Georges 15,6 14. Race - American Indien, 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 Yes No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes a No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Truck Driver News Distribution 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Wilbur Abraham Causion Sr. Sarah Elizabeth Gardner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Audra Jean Causion (Wife) 4456 St. Georges Avenue Baltimore, Maryland 21212 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MD. National Mem Park 4/26/99 Laurel, Maryland 22. Name end Address of Fecility Caple Funeral Service of Funeral Service Licenses 5502 Winner Avenue Baltimore, Maryland 21215 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth YRS Immediate Cause (Final disease or condition resulting In deeth) Duelto (or es a consequence of) 20 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributa to the causa of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy completion of cause 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No ER/Outpetient 3□ DOA 1 Inpatient 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

attending physician end for use es the burial-transit certificate be axecuted Box 68760, 80 thet the death dateched signed by t 9 Records, lew requires should peed page 2 : has The this certificate of Vital Physician: funeral

: After t

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completaly filled in by the fu

Attending Division

Physician/Medical Examin

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Completed

Be

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Certification:

Medical

29a. Certifier

(Check only one)

31. Dete filed (Month, Day, Year)

Physician

/Medical

Examiner

Director

Funeral

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Completed

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the

death

filed within 72 hours efter

Hygi

2 should be i

parmit. Pages 1 and 2 sh Department of Haalth end Important: If itam 27 ia m any injury or other traum phose.

Physician

/Medical

Examiner

itam 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, the Mod cal Examinar must be notified at

1 Yes 27. Menner of Deeth 1 Neturel

25. Wes case referred to medical exeminer?

5 Pending investigation

6 Could not be determined 3 ☐ Suicide 4 - Homicide

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number

29d, Dete signed (Month, Dey, Year) 422

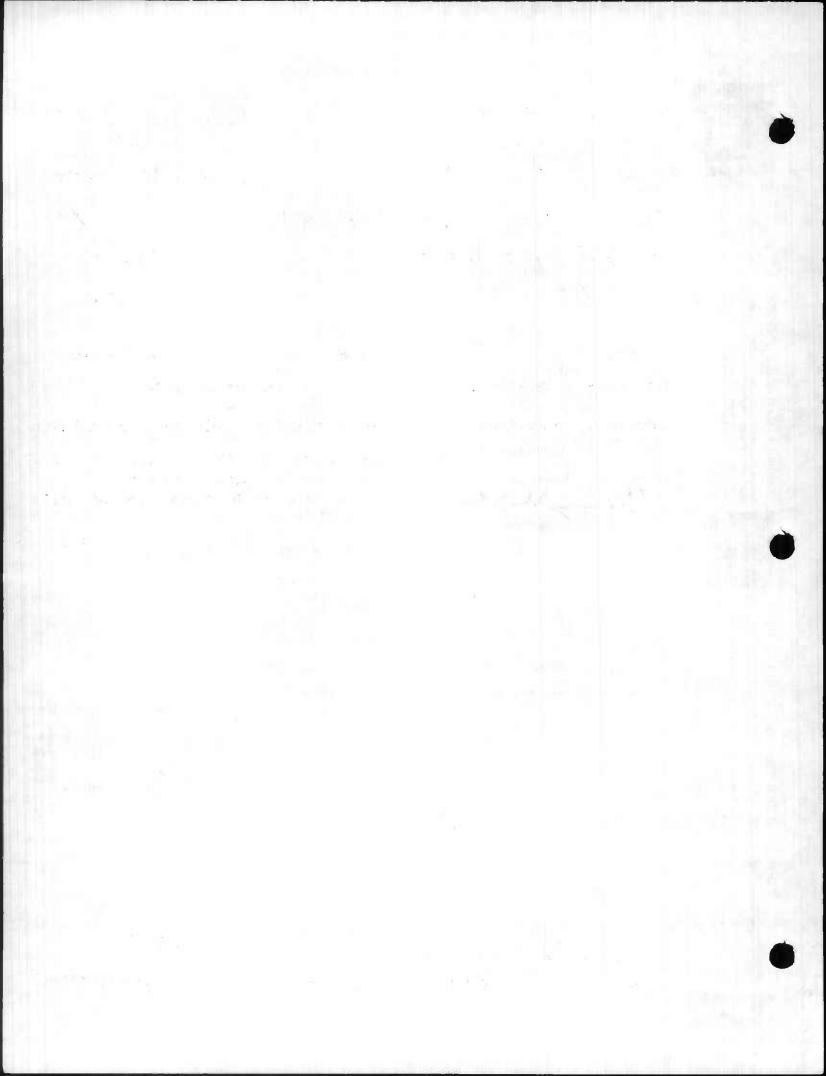
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

5601 Loch Raven Blvd Suite 206 Baltimore, Maryland 21239 David Goldsher, M.D.

State Registrar

APR 22 1999



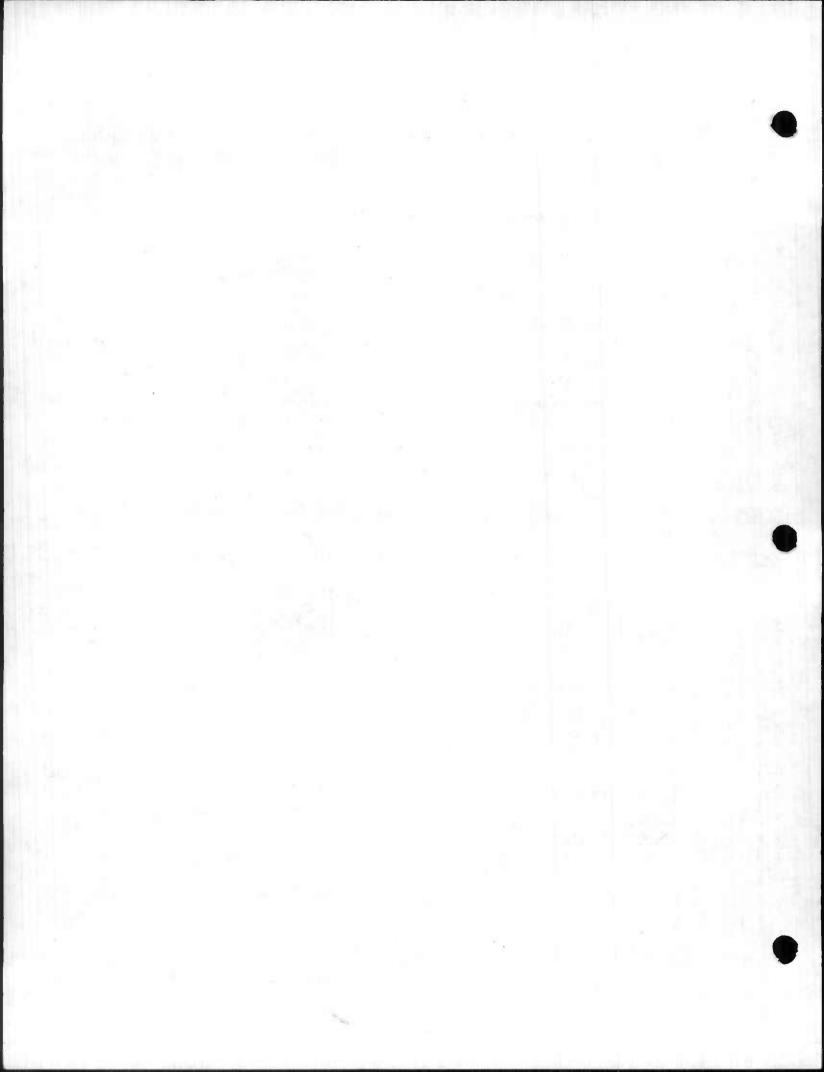


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES DAVID COLLINS, SR. APRIL 18 1999 6:18 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GENESIS ELDERCARE CATONSVILLE COMMONS CATONSVILLE BALTIMORE CO. If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 22 1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213-34-8996 1 M 2 F 61 Yes Tennessee Sept. **Director** Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mental Hygiens. Immortant: If them 27 is marked other than "natural", or theme 23a or 28a-f show any injury or other traumatic event, the Medica Examiner main be noticed. Ellicott City Md. Balto. Co. 1 Yes 2√7 No Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21043 USA 761 Oella Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Boiler Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Isabelle Chadwell Roy Armour Collins 20 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Cuffley-Brown (niece) 761 Oella Ave., Ellicott City, Md. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a, Method of Disposition Green Mount Cemetery 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/21/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Feculty—Polyniak Funeral Home P.A. ignature of Funeral Service Licensee Kevin E. Ecker 130 E. Fort Ave. Baltimore, Md. 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner rcf Ô The law requires that the death certificate be axecuted the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Sa P.O. Box 68760. Due to (or as a conate has been signed by the attending page 2 should be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Derobably 4 Unknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? certificate has 1□Yes 22 No 1 ☐ Yes 2 No of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural 1 TYes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. completaly 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10Cl 2 31. Date filed (Month, Day, Year) 32 Registrar's Signeture State 2 1999 2 Registrar APR



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 DRIL /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE MEDICAL BALTIMORE 7 REATER
Social Security Number ENTER 10WSON If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) Sex 1□M 2D F **Funeral** Months Director MICHIGAN with the Maryland 10a. State 10b. County 10c. City, Town or Location th and Mentel hygiene.
7 Is marked other than "natural", or hams 23s or 28s-f show treumstic event, the Medical Esercine, must be notified at 10d, Inside City Limits 1 ☐ Yes 2 1 No Funeral Director IIMONIUM 10a Stre 10f. Zip Code 10g. Citizen of What Country? 2300 illed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1□ Yes 2 No 21215-0020 WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOME HOMEMAKER 12 permit. Pages 1 and 2 should be file.
Department of Health and Meniel Hygh
Important if them 27 is marked
eny injury or other to Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å HOCK AMES HENRIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMONIUM, Md. 21093 TOXLEIGH RO SON LAWRENCE 2318 april 20 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, Stete Uneral Chapel

22. Name and Address of Fecility 4 Donation 5 Other (Specify) TOREST HILL, MACYLAND 21. Signature of February Septem Licens Evans Funeral Chapel YORK 1, monium death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 62 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burle-transit completely filled in the funeral director, page 2 should be detached for use as the burle-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detact 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, Àq 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 (Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 29a. Certifier 29b. Signature and 100 15504 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Halbuda Timonium. Md 21093 Dulaney 32. Registrar Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 2 1999

A DESCRIPTION OF THE PARTY OF T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Deeth 20^{Day} April **Physician** 11:35am Katherine 1999 Ruth Dawson /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Nursing Center Towson If Under 1 Year 8. Dete of Birth (Month Day Year) 02-25-1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Min. 1 M 2 1 F Hours Months Devs 77 Maryland Director 215-14-6361 Usuel Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a Stete 10h County 1 Yes 2 No N/A Baltimore 25a-f Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be n 3612 Evergreen Avenue Funeral 21206 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 X No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black White, etc. r than "natural", or iten the Medical Examiner 1 Never Memied 2 Married 1 ☐ Yes 2 🕱 No Specify: White Specify: à 3 X Widowed 4 □ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sales Person 12 Retail Sales 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be James P. Wilson Pearl Bary 19b. Meiling Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Relationship (Typa, Print) 2928 Timothy Dawson -Son Erdman Ave. Baltimore, Hern 27 Md. 21213 20b. Placa of Disposition (Nama of cematary, cramatory or othar placa) 20e. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State Parkwood Cemetery 4-23-99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. 21. Signeture of Funerel Servica Licensee 22 Name and Address of Facility Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md. 21214 Lovanne 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest shock, or heart feiture. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physicien end the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In deeth) Lest Due to (or es a consequence of) Physician/Medical Due to (or es e consequenca of): 80 USB signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown py 24b. Were autopsy findings evailable prior to completion of cause of deeth? should s 24e. Wes an autopsy Completed After this certificate has funeral director, page 2. 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 2 Accident 1 Yes 2 | No s efter deet 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) n 24 hours effer ne Funeral Direct pletely filled in b 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner es stated. | Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one)

Sauson Hori so,1999

1 and 2 should be Montal

Pages ъ

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

deeth.

Baltimore,

State

31. Date filed (Month, Day, Year) Registrar

30. Name end

29b. Signeture and titlerof certifi

APR 22 1999

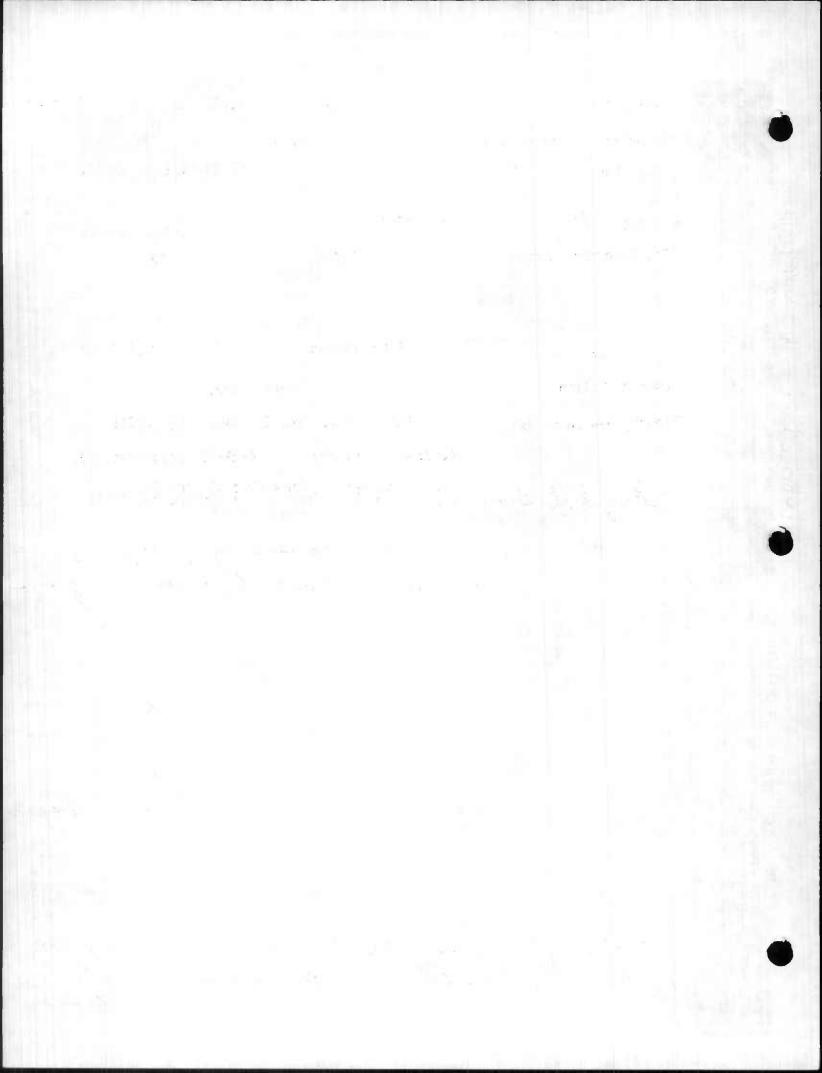
32. Registrer's Signeture

use of deeth (Ite

Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Nema (First, Middle, Last) **Physician** P /Medical 4b. City, Town, or Location of Death 4c. Gounty of Death 4a Facility Name (If not institution, give street and number) **Examiner** Romwell 7. Age (In yrs. last birthdey) If Under 1 Yaar 9. Birthplace (State or Fpreign 5. Social Security Number 6. Sex 8. Deta of Birth (Month, Day, **Funeral** Months Deys Hours Min 10 M 20 F 213 - 05 - 227 Usuel Residence of Decedent 3 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic svent, or Medical Examines must be normed as 10e Stete 10b. County City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Cottage (1-4or 5+) 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Be 10 19b. Meiling Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a., Informent's Neme/Reletionship (Type, Print) VIRGINIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposit(or 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from Steta 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name end Address of Fecility E Marse vans 23a. Part1. Ehtar the diseasa, or complications that caused the death. Do not enter tha mode of dying such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each line. 21234 Approximata interval Between Onsat and Deeth Physician Acadent Immediate Cause (Finei disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting to deeth) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or es e consequence of) 98 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably W by 24b. Wera autopsy findings available prior to 24a. Was an autopsy Completed peen completion of cause of death? cartificate has b 2 1 No 1 Yes 1 Yas 2 No Hospital or Attending Physician: funaral director, 25. Wes case referred to medical axaminar? Be 26. Plece of Deeth (Chack only one) Hospitel: Othar: 4 Kursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 Inpetiant 2 ER/Outpatient 3 DOA After this 27. Mennar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Dey Year) 1 Netural 2 Accident 5 Panding Investigation 1 🗌 Yas death. ofter death Director: 3 Suicida 6 Could not be To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mennar statad. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signetura and title a continu 29c. Licanse number

State Registrar 31. Data filed (Month, Dey, Year)

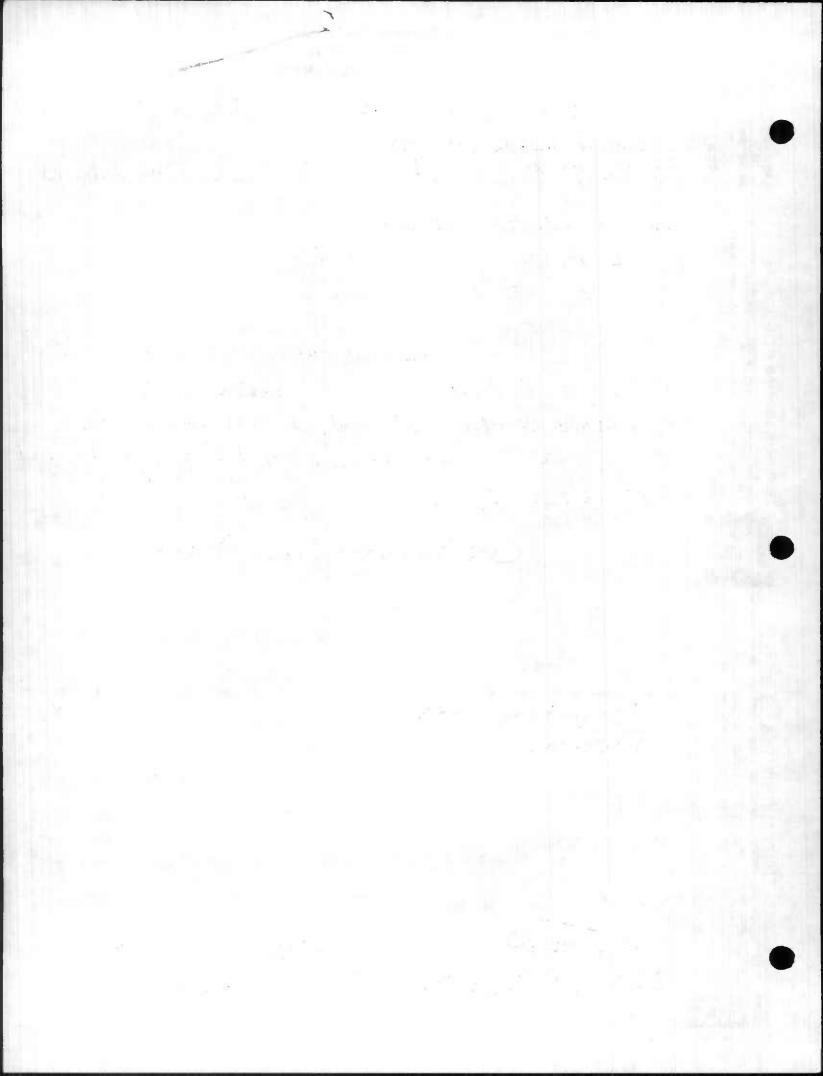
30. Nama and addrass of person

Parkway 32 Registrar's Signature

complated causa of death (Itam 23a) (Type, Print)

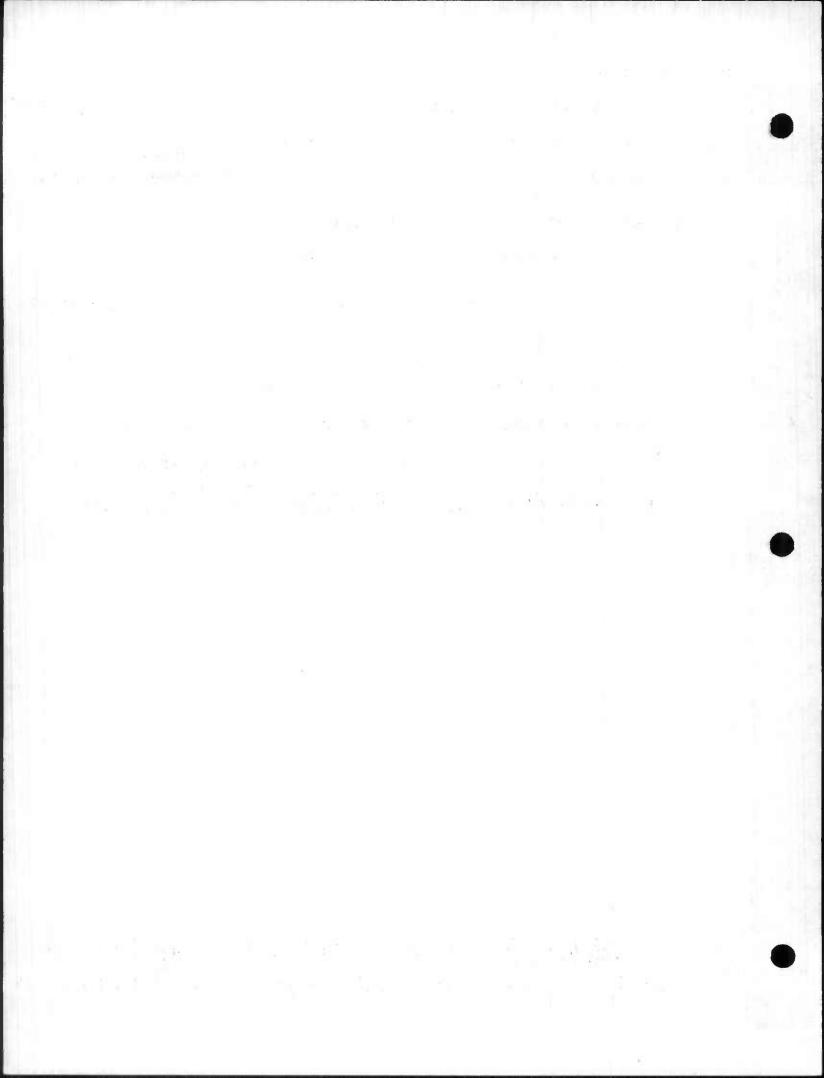
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ZIAD KHALIL MIRZ



State of Maryland / Department of Health and Mental Hygiene

| Item | #8 | State of Maryland DerFH G771 5/3/99 EW 1. Decedent's Name (First, Middle, Last) | Certificate of | | | eg. No. | 3. Time of Death | | |
|--|------------------------|--|--|-----------------------------------|--|--|--|--|--|
| Physici /Medio | al | LUE DELL DEMA 4a. Facility Name (If not institution, give street and number) | | 4h City Town or Lo | Month APRIL | 19, 1999 | 2.48 AM | | |
| Examir Funeral Director | ier | 3229 RAVENWOOD AVENUE 5. Social Security Number 6. Sex 1 M 3 F 62 | | BALTO. | 8. Date of Birth | N/A 11-03-36 9.B | irthplace (State or Foreign Country) | | |
| | J. | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, | Town or Location | | ALTO, MD. 21213 Deta 20c. Location - City or Town, State ALTO, MD. 21213 Deta 20c. Location - City or Town, State ALTO, MD. 21213 FUNERAL HOME REFT BALTO, MD. or respiratory errest, | 10d. Inside City Limits | | | |
| with the M 3a or 28e-f | il Director | MARYLAND N/A 10e. Street and Number 3229 RAVENWOOD AVENUE | BALTIMORE 10f. Zip Code | 21213 | 1 | | Yes 2□ No Country? | | |
| and 21215-0020 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28e4 show event, the Medical Exeminer must be not led at | by Funeral | 11. Marital Status 1 Never Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Detes: | 13. Wes Decedent of If Yes, specify Cub | | ecify Yes or No- Rican, etc.) | Bleck, Wh | | | |
| 21215-0020 d within 72 hours af giena. pr than "natural", or , the Wedical Exam | Completed I | 15. Decedent's Education (Specify only highest grade completed) Elemantery/Secondary (0-12) College (1-4or 5+) | 16e. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire | petion during most of workind) | ng | 16b. Kind of Busines | ss/Industry | | |
| Baltimore, Maryland 21215-C pemit. Pages 1 and 2 should be filed within 72 hc Department of Haelth and Mental Hygiena. Important: If item 27 le marked other than "netul any injury or other traumatic event, tra Medical any injury or other traumatic event, tra Medical any Engles. | To Be Co | 12TH N/A 17. Father's Name (First, Middle, Last) WALTER SIR RALEIGH KNIGH | DIET TECHNIC F | 18. Mother's Neme | (First, Middle, A | Reg. No. Dept | KINS HOSP. | | |
| re, Mar 1 and 2 sho Haaith and lem 27 is me other traum | | 19e. Informent's Neme/Relationship (Type, Print) JESSE DEMARY / HUSBAND 20e. Method of Disposition 20b. Ple | 3229 RAVENWO | OD AVE. BA | LTO, MD | | | | |
| Baltimore, pemit. Pages 1 ar Department of Haa Important: If Item 2 any injury or other | | Durial 2 Cremetion 3 CHemoval from Stete | ZION CEMETER 22. Name and Addre | Y AF | PR. 23, | 1999 BALT | | | |
| | | 23a. Part. Enter the disease, or complications that caused tha deeth. shock, or heart failure. List only one cause on each line. | 1. 1412 E. PI | RESTON STR | EET BA | T.TO. MD. | 21213 Approximata Interval Between Onset end Death | | |
| Physician /Medical Examiner | | Immediate Ceuse (Finel disease or condition resulting in daath) e. Cerebrov Dua to (or a | asculat a | cclden | + | | 1 day | | |
| I HECOTOS, P.O. BOX 68/60, The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be deteched for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events. | is a consequence of): | | | | 10 years | | |
| a daath certifi the attending | Physician/Me | d | ing In the underlying cause gh | ven In Pert I. | 23b. Did to | Reg. No. eath Day 19, 1999 th 4c. County of Dee N/A inth 11-03-36 ey, Vear) 10g. Citizen of What Co U.S.A. 10g. Citizen of What Co U.S.A. 14. Race - Ame Bleck, Whit Specify: AFR 16b. Kind of Business JOHNS HOPK a, Meiden Surmame) 20c. Location - City or 1999 BALTC HOME BALTO, MD. errest, 1 tobacco use contribute CALTO, MD. errest, | te to the cause of death? | | |
| ulras that than signed by the | þ | obesity | | | | | Probably 4 Unknown D. Ware autopsy findings | | |
| VITAI HECOTOS, Iclan: The law requires ti certificate has been signe rector, paga 2 should be o | Completed | | | | perlom | ned? | available prior to completion of cause of deeth? | | |
| ng Phys | Certification: To Be (| 27. Menner of Deeth 1 Netural 5 Pending (Month, Day Year) 2 Accidant Investigation 3 Suidde 6 Could not be | 8b. Time of Injury M 1 | Yes 2 □ No | me 5 Reside 28d. Describe ho | | | | |
| Hospital 24 hours Funeral staly filled | edical Certif | 4 Homicide determined 206. Piece of Injury - At nom building, etc. (Specify) 29e. Certifier (Check only Medical Examiner: On the basis of exemination | e, ferm, street, fectory, offica edge, deeth occurred at tha tin n end/or investigation, in my o | ma, date end place, a | City or Town | o, Stete) | es steted. | | |
| To the within 2 To the compla | Mec | 29b. Signeture end title of cartifier | A . 29c. Licens | | | 9d. Dete signed (Mor | o [999 | | |
| | | 30. Nama end eddrass of berson who complaid cause of daath (Itam 2 | | ES-00 Nepkins | Hospi | H) Br | Hume MD | | |
| Sta Registra | | APR Z Z 1999 | Asout 1 | | * | ¥ | / | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 9:02 MARCH 29 Albert Evans /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Poseda /e If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 1932 SQUARE 6. Sex BAITIMORE HOSPILAL Center TRAUKIIN If Under 1 Yaar 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1**X**0 M 2□ F Months Davs 66 May 8, 250-44-5530 unknown Usual Residence of Decedent 10c. City, Town or Location 10d. Inalde City Limits 10a State 10h County 1 Yes 2 No Maryland Baltimore Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Eastern BLvd. 21221 linknown Funerai 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U.S. Amad Forces? unknown 1 □ Yas 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1K Never Marriad 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: black by 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) unknown unknown unknown unknown 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middle, Last) 2 unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from State 4 □Donation 5 XOther (Specify) in state 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board, 655 W. Baltimore Street Di/rector 23a. Part | Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · HYPOXIA 5 HOURS disease or condition resulting in death) Due to (or es e consequence of): Examiner neu monit Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): . GASIROINTESTINA Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Netural 5 Pending 1 Tes 2 🗌 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

that the death certificete be executed pue Box 68760 physician Division of Vital Records, P.O. certificate Mospital or Attending Physicien:
 124 hours after death.
 Funeral Director: After this certifice.

bunel-tran the signed by the e page 2 director.

Funeral

Director

7 is marked other than "natural", or ferms 23a or 28a-f shov traumatic event, the Medical Examiner must be notified as

permit. Pages 1 end 2 should be filed within 72 hours efter death v. Depertment of Heelth and Mentel Hygiene. Important: if flem 27 is marked other than "natural", or items 23s any injury or other traumatic avant

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Marylend

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Data signed (Month, Dey, Year) 29c. License number

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Spune DR. BALTIMORE, MARYLAND 21237 DR. MADAI FRANKlin 9000 don 31. Dete filed (Month, Dey, Year)

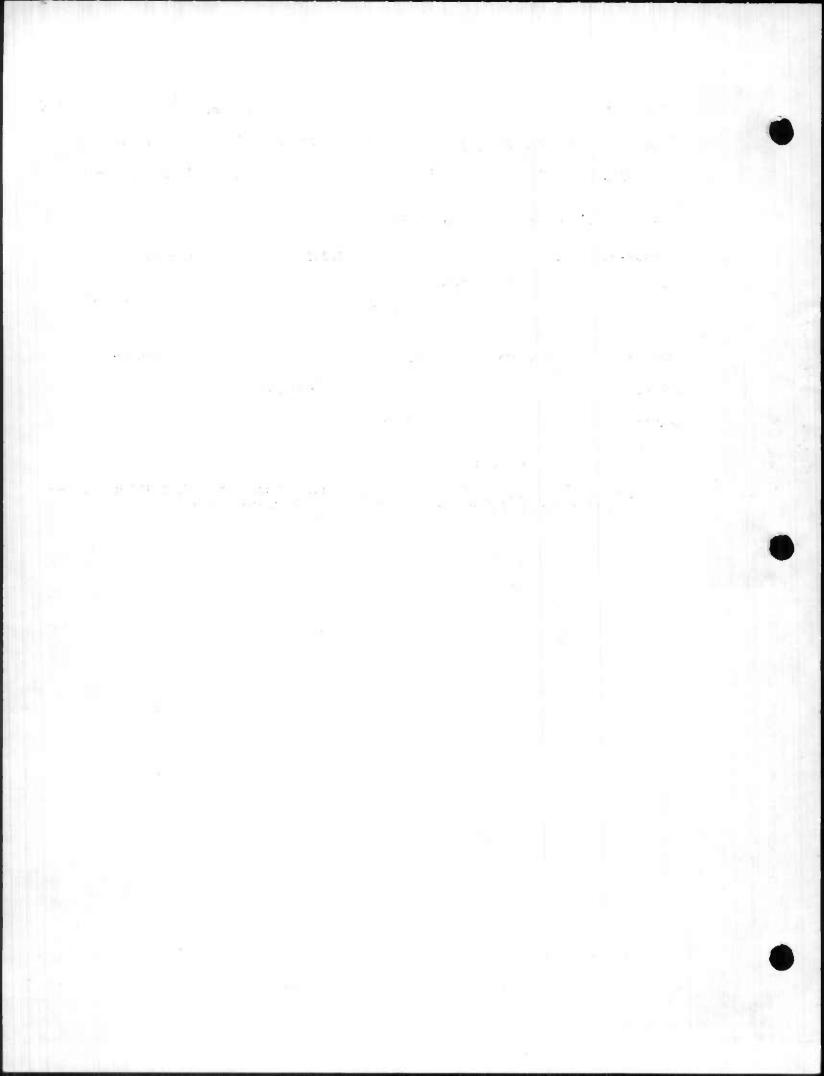
State Registrar

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32. Registrar's Signature

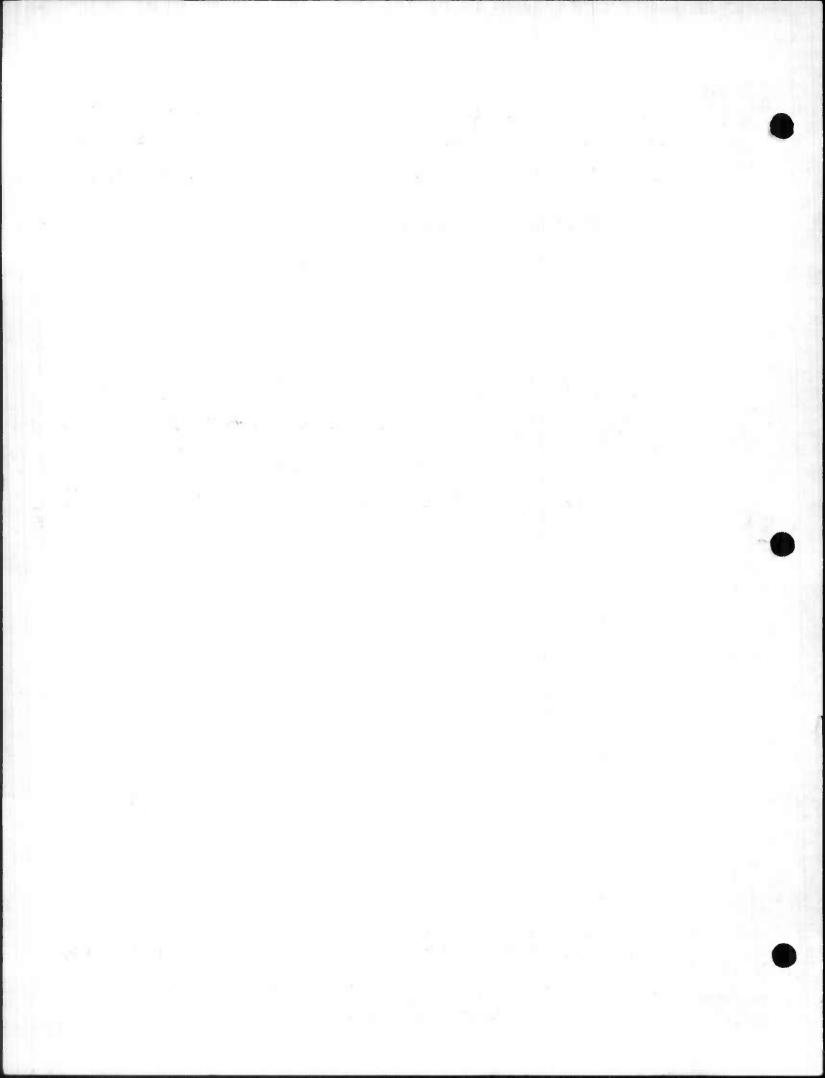
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death Month Dey **Physician** CVANS 19, Howard APRIL 1999 10:40 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Joseph Medical Center Towson Saint If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (Stata or Foreign
Country) **Funeral** Months Days 220-20-202 154M 2□ F Director Usual Rasidance of Decedant the Maryland 10a. Stata County 10b 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Ma nekvill 1 ☐ Yas 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? filed within 72 hours efter death with 2402 21234 Funeral Wes Decedant Evar in U,S. Armad Forces? 1 DYas 2 □ No If Yas, Giva Yaar or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Rece - Amarican Indian, Black, Whita, etc, 11. Maritel Stetus 1 Navar Married 2 Married Specify: White 1 Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 18b. Kind of Businass/Industry other than Elementary/Secondery (0-12) Collega (1-4or 5+) Hygiene accountant /d traumetic event, . Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked out 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Baltimore Md 21234 Madelin other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Pate 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice License 22. Name end Addrass of Facility Vans 8800 23a. Pert1. Entar the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haert failure. List only one ceuse on each line. Approximeta Intarval Batween Onset and Death Physician /Medical Immediete Causa (Final METASTATIC CANER OF LUNG disaasa or condition rasulting in death) Examine Due to (or es a consequance of) Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated avents rasulting in daath) Last and Dua to (or as e consequance of) physician sthe burial Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as e consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown þ 24b. Wara autopsy findings aveilable prior to completion of cause of daath? 24e. Was an autopsy performed? Completed page 2 2 X No 2 No certificate 1 Tas To the Hospital or Attending Physician: director, 25. Was cesa rafarred to medicel Be 26. Placa of Death (Check only ona) axaminar Other: 4 Nursing Home 5 Residence 8 Other (Specify) ٩ 1 ☐ Yes 2 No 1 inpatient 3 DOA 2 ER/Outpetient this After this Certification: 27. Mannar of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Naturel 2 Accident 5 Panding death. 1 TYas 2 No investigation within 24 hours after death To the Funeral Director: / completely filled in by the 3 Sulcide 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Phyeician: To tha best of my knowledge, deeth occurred at tha tima, data end piece, end due to the causa(s) and menner as stated.
2 Medicel Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, dete end piece, end due to tha ceuse(s) and manner stated. 29a, Cartifian Medical 29b. Signatura and titla of certifial 29c. Licensa number 29d. Data signed (Month, Day, Year) 37254 4-20-99 30. Nama and address of person who complated ceuse of deeth (Item 23a) (Type, Print) BOON P. LIM, 31. Data filad (Month, Day, Year) M. D., 7601 OSLER DRIVE, TOWSON, MD 21204 32 Ragistrar's Signatura State

DHMH 16 Rev 6/95

Registrar



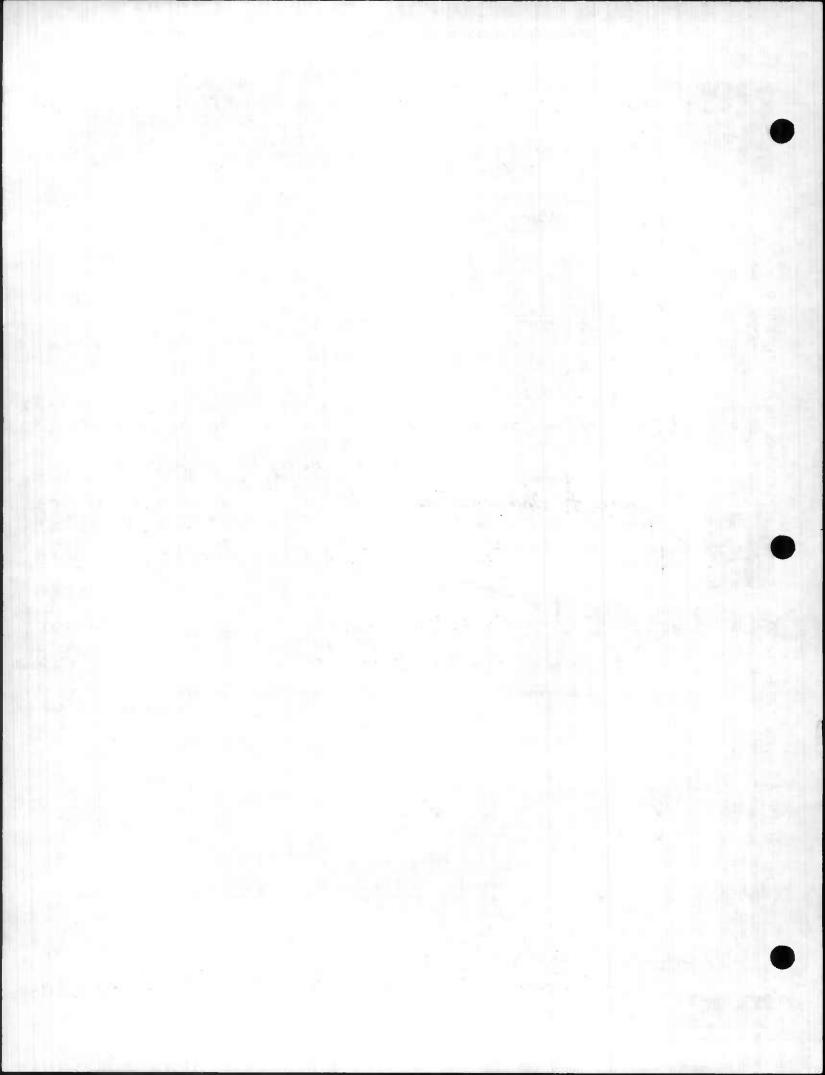
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 0010 1dine /Medical 4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore pital If Under 24 Hrs. 8. Dete of Birth Hours Min. (Mogth, Day, Year) If Undar 1 Yaar 6 Sex Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Months Deys 81 218-07-5193 Yrs. Director Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Mandar Department of Hastib end Mental Hygiens.
Important: if firet 27 is transfed other than "natural; or items 23a or 28a-1 ahow any injury or other traumatic avant, it is the 25 and 10 and 1 1 Yes 2 No Baltimore Ma Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 3237 5 21215 emite Avenut Funerai 12. Was Decedant Evar In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 14. Race - Amarican Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 XNo Black Specify: ρ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) - wate Homes College (1-4or 5+) th grade Domestic NA 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter Marie Jones Johnson 10 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Z/// 7 Sih Son Oaks Trails Owings Mills, Md Fulton ennis 20b. Place of Disposition (Neme of cemetery, cremetory or other plece, Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramovel from State 4 □ Conation 5 □ Other (Specify) 21 rign ture of Funerel Service Licensee 22. Name end Address of Facility 2/215 any ic kerch 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, tok, or heart failure. List only one cause on each line. 140 Approximete Intervel Between Onset end Deeth **Physician** GASTroINTESTINAL Bleeding Imm or te Cause (Finel dise or condition resulting in deeth) /Medical Examiner Due to (pr as a consequence of): Physician/Medical Examiner ed by the attending physician and detached for use es the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, 11c 23b. Did tobacco use contribute to the cause of death? Perl II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Perl I. 475 Unknown 1 Yes 2 No 3 Probably been signed be should be deta by 24b. Were autopsy findings eveileble prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed page 2 s 2 A No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Yeer) : After thi 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Tima of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Investigetion I Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homlcide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end granner stated. 29a. Certifier edicai (Check only one) within 2 29d. Dete signed (Month, Day, Year) 29b. Signature and title of MO cause of deeth (Item 23e) (Type, Print) 30. Name and address of person's vedere 240 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State APR 22 1999

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** eannette /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number, Examiner MaNOR CIONIA If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Dey, 9 Birthplece (Stete or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Deys Hours Min 1 M 2 F 218-16-1627 Usuel Residence of Decedent Yrs. Director with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f ehow item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 210/4 death v Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or ite 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2⊠No Specify Specity: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Maiden Sumeme) 18. Mother's Neme (First, Middle, 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 20b. Place of Disposition (Name of cametery, crametory or other place) AREL 18 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removel from Stete
4 Donetion 5 Other (Specify) any injury or o 22. Name end Address of Fecility 21. Signature of Suneral Service Licensy 23a. Part F. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical **Examiner** Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-trans Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In death) Last Due to for as e consequency or) Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part ff, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No P 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveileble prior to 24a. Wes an autopsy performed? page 2 should Completed been s completion of cause of death? certificate has 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes case referred to medical examiner? funeral director, 26. Place of Deeth (Check only one) To the Hospital or autorium, within 24 hours after death.

To the Funerel Director: After this cer Hospital Other: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stelled. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifie 29c. License number

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State Registrar

Registrar APR 2 2 1000

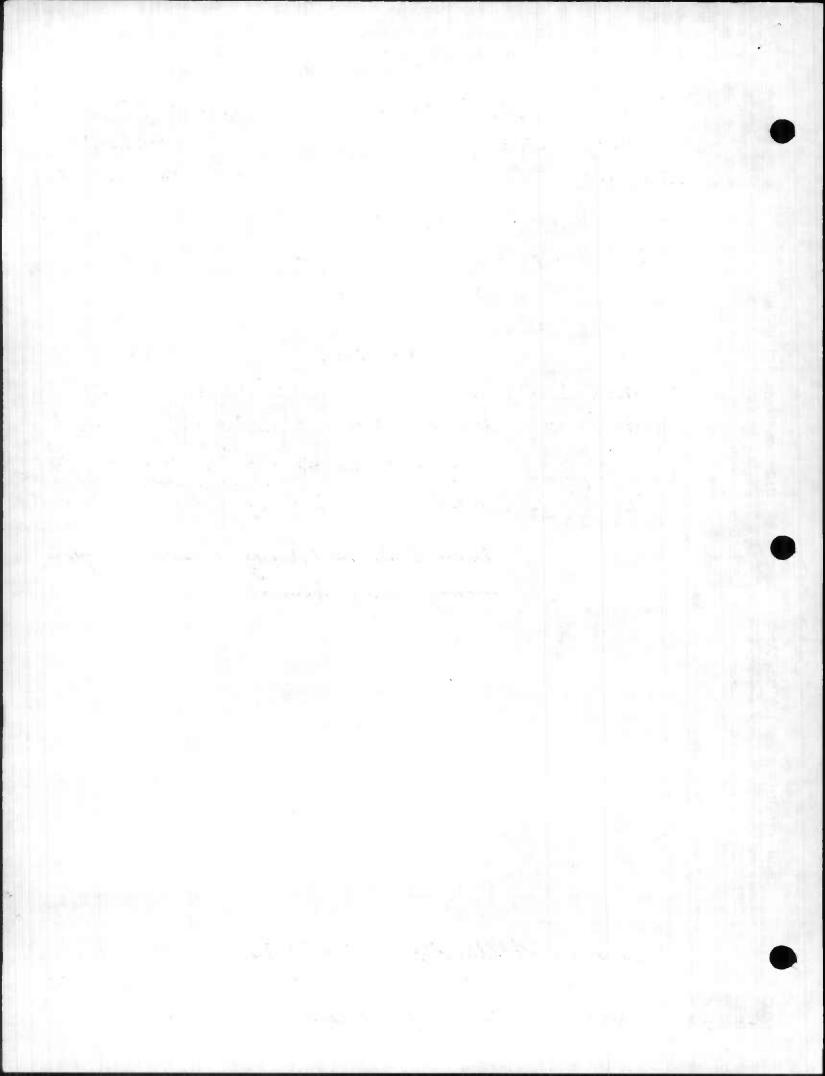
31. Date filed (Month, Dey, Year)

30. Name and address of person, who complete

Aports Signeture B. Sports

deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 0:30 Am 3AM3 INNA CIRACE 1999 APRIL 4c. County of Death

BALTIMORE 4b. City, Town, or Location of Deeth 4e Fecility Name (If not Institution, give street end number) CENTER. HOSPITAL RANDALLSTOWN NORTHWEST | If Under 1 Year | if Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year, JUNE 7, 19 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 M 2 X F 219-07-0439 77 Yrs. VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1312 GREENWOOD ROAD 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Biack, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 Yes 2 No Specify: BLACK 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) ADMISSIONS COORDINATOR STATE OF MARYLAND 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) JACOB H. MARY E REVELS TEAGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOAN DAVIS / DAUGHTER 1312 GREENWOOD ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 4/15/99 TOWSON, MD 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, 1 oberto MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) · ACUTE INFARCTION MYDCARDIAL DISEASE. CORONARY ARTERY Due to (or as e consequence of) Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Was en eutopsy

Physician /Medical Examiner

physician end the burial-tran

50 158 0 ed by the e

signed by t

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certificete Physician:

this : After this funeral

Director: A

or Attending

Hospital

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24 hours efter Funeral Direc

within 2

The law requires that the death certificete be executed

Box 68760

Division of Vital Records, P.O.

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Physician/Medical

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Certification:

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Physician

/Medical

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an "naturel", or items 23a or 28a-f ehov Medical Examiner must be ricitled at

permit. Pages 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iter eny injury or other treumatic event, the Medical Experiment page.

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deeth

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

AINOMIA. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

1 Nnpatient 2 □ ER/Outpetlent 3 □ DOA 1 Yes 2 No 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 6 Could not be 3 ☐ Suicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 No

1 🗷 Certifying Phystolan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

PHYSICIAN 29b. Signature and Atle of cartities HOUSE D 42723. Joma

29c. License number 29d. Date signed (Month, Dey, Year) APRIL

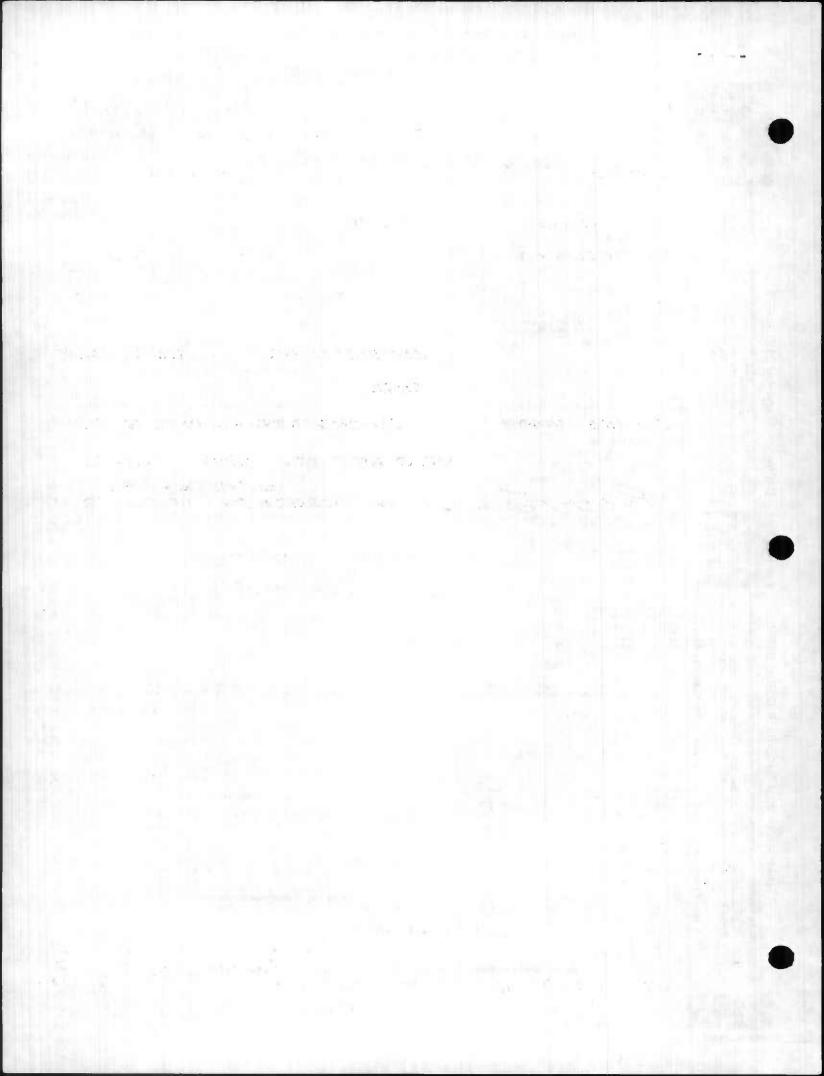
MORE MORE STREAM RO(70) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 37 45 236. HARISH BAL VVERALAGUI

31. Date filed (Month, Dey, Year)

4 Homicide

32. Registrar's Signature south

State Registrar

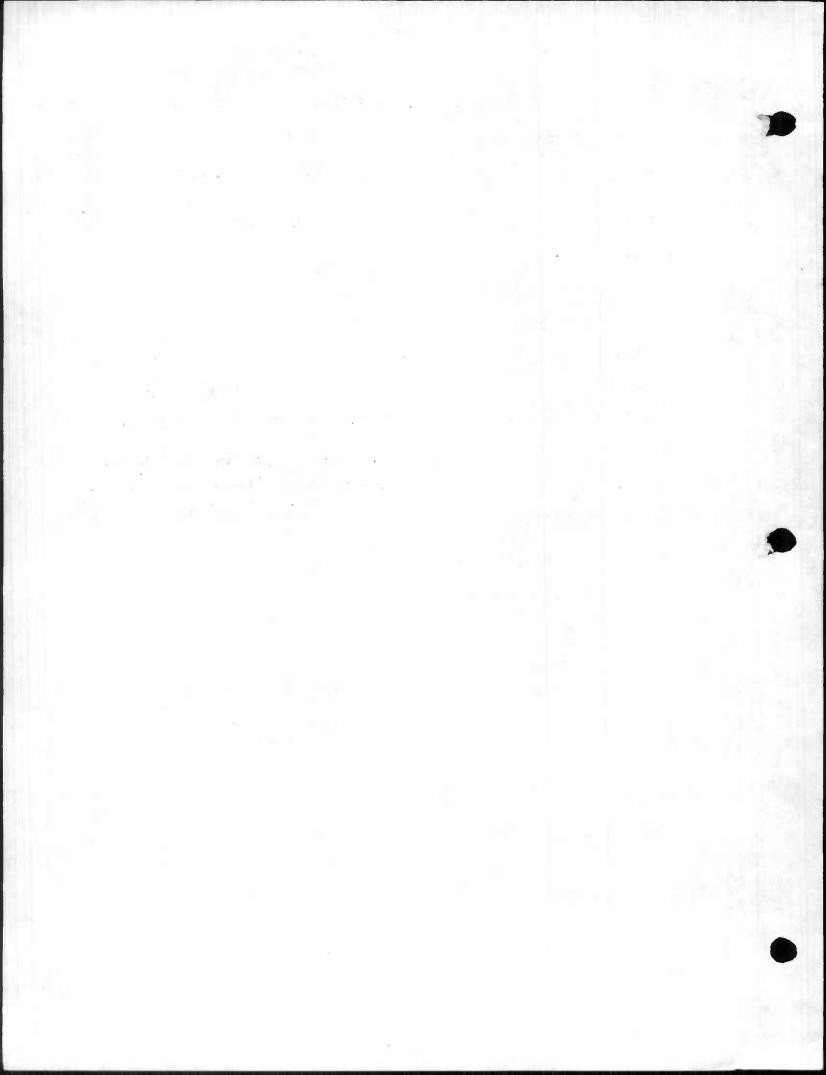


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 19, 1999 Physician Griffiths Patricia E. 8:40 PM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 6620 Marne Avenue Baltimore City N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 X F Yrs. 220-36-5361 58 Director Oct. 6,1940 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Hedical Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6620 Marne Avenue 21224 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Stalus Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: Specify by 3 ☐ Widowed 4 ☑ Divorced "netural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien important: If Item 27 is marked other that any filury or other traumatic award, that DADGs. 12 Years Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Monroe Hill Imogene Sliwinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Page/Daughter 2017 Bear Ridge Road 104 Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/23/1999 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Pheumonia disease or condition resulting in death) week Examiner Due to (or as a consequence of) cancer years requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown Primary bilians circhosis Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified hy 023809 4/20/99 Churchin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cancer Ctr., 22 S. Greene St., Baltmon, Mo 21201 Doyle, M.D Greenebaum Ausha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 22 1999

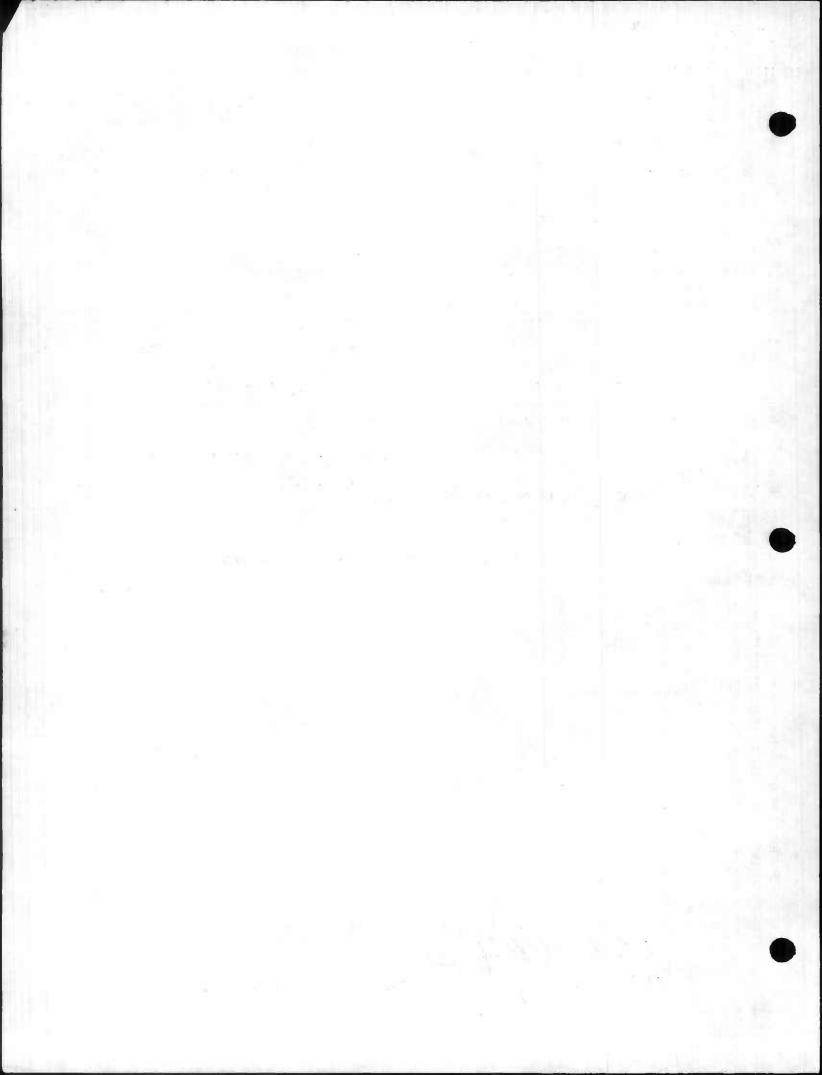
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DHMH 16 Rev 6/95



| | -2235-005 | INFORMANT G772 6-1 | | ite of Mar | | epartment of Certificate of | | Mental Hy | w w | | 3244 | | |
|-------|--|---|--|----------------------------------|--|---|--------------------------------|--------------------|------------------|----------------|---|--|--|
| AMEND | TIEM. #5 PER | Decedent's Nama (First, M.) | | | | orumouto or | Douili | 2. Date of D | Reg. No. | | 3. Time of Death | | |
| | Physician | Louis Ge | eppi | | | | | Month APRIL | Day 17, 19 | Year 999 | 1050 AM | | |
| | /Medical Examiner | 4a Facility Nama (If not Institu | ution, giva street a | and number) | | | 4b. City, Town, or | _ | | | 1050 AM | | |
| | | 908 BARDSWELI | ROAD | | | | WESTVIEW | J | BALT | IMORE | | | |
| | Funeral | 5. Social Security Number 217-12-8725 | 6. Sex | | In yrs. last birth | day) If Under 1 Yea Months Days | | | rth ev Year) | 9. Birthp | lace (State or Foreign | | |
| | Director | 218-18-0739 | 1 M 2 | UF 74 | Yı | S. Working Day | Trouts Will. | 05-26- | | Baltimore, MD | | | |
| | Du B | Usual Rasidence of Decedent 10a. Stata 10b. Cou | | 11 | Oc. City, Town o | or Location | | | | | Od. Inside City Limits | | |
| | Aaryli Sho | | timore | | Westvie | | | | | 1 ☐ Yes 2 ☐ No | | | |
| | vith the Mar or 28a-f s be notified Director | 10e. Street and Number | CIMOIC | | MESTATE | W 10f. Zip Code | | 1 | 10g. Citizen of | What Cour | ^ | | |
| | Vith Vith | 908 Bardswell | l Road | | | 21228 | | | USA | 77.14. 000 | ., | | |
| | ther death vines 23 door man | 11. Marital Status | 12. Wa | s Decedent Eve | er in U,S. | 13. Was Decedent of | Hispanic Origin? (5 | Specify Yes or N | o- 14. Rac | ce - Americ | an Indian, | | |
| D20 | 1 Never Marriad 2 N | Married TX | ned Forces?]Yas 2 ☐ No | | and the same of th | ban, Mexican, Puer | to Rican, etc.) | | ck, White, | | | | |
| | O20 | 3 Widowed 4 □ Divore | ced Ye | es, Give ar or Dates: W | WII | 1 ☐ Yes 2 Æ No | Specify: | | Specif | whit | e | | |
| | 1 21215-0 led within 72 ho tygiene. Tr. tre matters tr. tre matters Completed | 15. Dece | dent's Education | olated) | 16a. D | ecedent's Usual Occi | upation e during most of wo | dkina | 16b. Kind of B | | | | |
| | To difficient of the state of t | Elementery/Secondary (0-1) | | llege (1-4or 5+) | | Give kind of work don le. DO NOT use retir | ed) | | | | | | |
| | Cor Cor | 12th | | | | Conductor | | | oad | | | | |
| | Be Be | 17. Father's Nama (First, Midd | | | | | 18. Mother's Na | | | 110) | | | |
| | hould diversify | Antonio D. 19a. Informant's Name/Ralati | | intl | 10h I | Aailing Address (Stree | | regonio | | Ctata 7in | Codel | | |
| | Ma dd2 s dd2 s dd2 s dd2 s dd2 s | William Satte | | | | O Broken I | | | | | Code) | | |
| | Head of the of the | 20a. Method of Disposition | LILCIA/III | | 20b. Place of D | isposition (Name of | Ī | Date | 20c. Location | | wn, State | | |
| | TO Sage | XXBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other | | I from State | | crematory or other pl thedral Ce | | 4/21/99 | Baltime | ore | БМ | | |
| | Utic Bartim Portan Injur | | | | 1,0,7,00 | | | 1/21/55 | Daretin | orc, | | | |
| | W Segretary | 1 mm 1 | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton Schwab Funeral Home, | | | | | | | | | | |
| | | 23a. Part1. Entar tha disease shock, or haart failure. I | or complications | s that coused the | e death. Do no | 736 Edmon | dson Aver | oue, Bal | to, Md | 21228 | Approximata | | |
| | Physician | shock, or haart failure. I | List only one caus | se on each line. | | | • | | | | Onset and Death | | |
| | /Medical | Immediata Causa (Final | 7 | | 1 | C3: | - 1 p! | | | 1 | | | |
| | Examiner | disaasa or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): | | | | | | | | | | | |
| | P = E | 10.71 | | | • | | | | | | | | |
| | I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | | |
| | 8760, sate be exchysician a the burial- | Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury | 1 | | | | | | | | | | |
| | P.O. Box 68760 at the death certificate be d by the attending physicial eletched for use as the bur Physician/Medical | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | |
| | ontification of the season of | | | | i | | | | | | | | |
| | , P.O. BOX 68 that the death certificated by the attending plant detached for use as the physician/Mec | | | | | | | | | | | | |
| | P.O. nat the de d by the delached Physic | Part II. Other algnificant cond | litions contributin | g to death but n | not resulting in t | he underlying cause g | given in Pert I. | | | | the cause of death? | | |
| | ned b | | | | | | | 10 | Yes 2LINO | 3 170 | bebly 4 ☑ Unknown | | |
| | of Vital Records, Physician: The law requires the this certificate has been signe real director, page 2 should be continued by the completed y the complete by the complet | | | | | | | | an autopsy | 24b. W | ere autopsy findings | | |
| | Show with | | | | | | | | ormed? ECTION | 00 | ailable prior to mpletion of cause death? | | |
| | The lay | | | | | | | | | | Yes 2□ No | | |
| | Vital I | 25. Was case raferred to med | ical | | | | 26 Place of De | eth (Check only | ΛΛ | '' | 1165 20160 | | |
| | of Vita Physician: this certificatel director, To Be (| examiner? 1 X Yas 2 No | Hospital | l: 1 Inpatient | 2 ☐ ER/Outp | atient 3 DOA | Whor | | idence 6 🗆 Ot | har /Caacil | ial . | | |
| | Physical of Physic | 27. Mennar of Death | 28a. | Date of Injury (Month, Day Yo | | ne of 28c. Inj | | | how injury occur | | 77 | | |
| | Sion tending Fleath. Iter: After the funer cation: | 1 XNatural 5 Per | nding estigetion | (Month, Day Yo | <i>'ear)</i> Inju | | ork? ☐ Yes 2 ☐ No | | | | | | |
| | Division or Attending after death. Director: After d in by the fune ertification | 3 ☐ Suicida 6 ☐ Cou | ald not be 28e. | Place of Injury | - At home, fem | , street, factory, office | Э | | (Street and Num | ber or Run | Il Route Number, | | |
| i | Divi | 4 Homicida | | building, etc. (| Sреспу) | | | City or 10 | wn, State) | | | | |
| | Division (To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification: | 29e. Certifier 1 Certif | lying Physician: | To the best of m | ny knowledge, o | leath occurred at the or investigation, in my | time, date end place | e, and due to the | cause(s) and m | anner as s | tated. | | |
| | the H the F the F | one) | an | d manner stated | d. | | | arred et use ture. | | | | | |
| | To the Com | 29b. Signature and titla of cert | ifier | 1., | | | nse number | | 29d. Date signe | | | | |
| | | Meoder | MI | | Cry | (| OCME | | APRIL 1 | .8, 19 | 199 | | |
| - | | 30. Name and addrass of pers | | d caus deat | th (Item 23a) (Ty | pe, Print) | | | | | | | |
| 1+1 | | THEODORE | | | | Penn Stree | t, Baltim | ore, Mar | ryland 2 | 21201 | | | |
| 10 | State | 31. Date filed (Month, Day, Ye | (QQQ | 32. Registrar's | | | | | | | | | |
| Ony | Registrar | | 1033 | "Ly stad | 19 | from st | | | | _ | | | |

DHMH 16 Rav 6/95



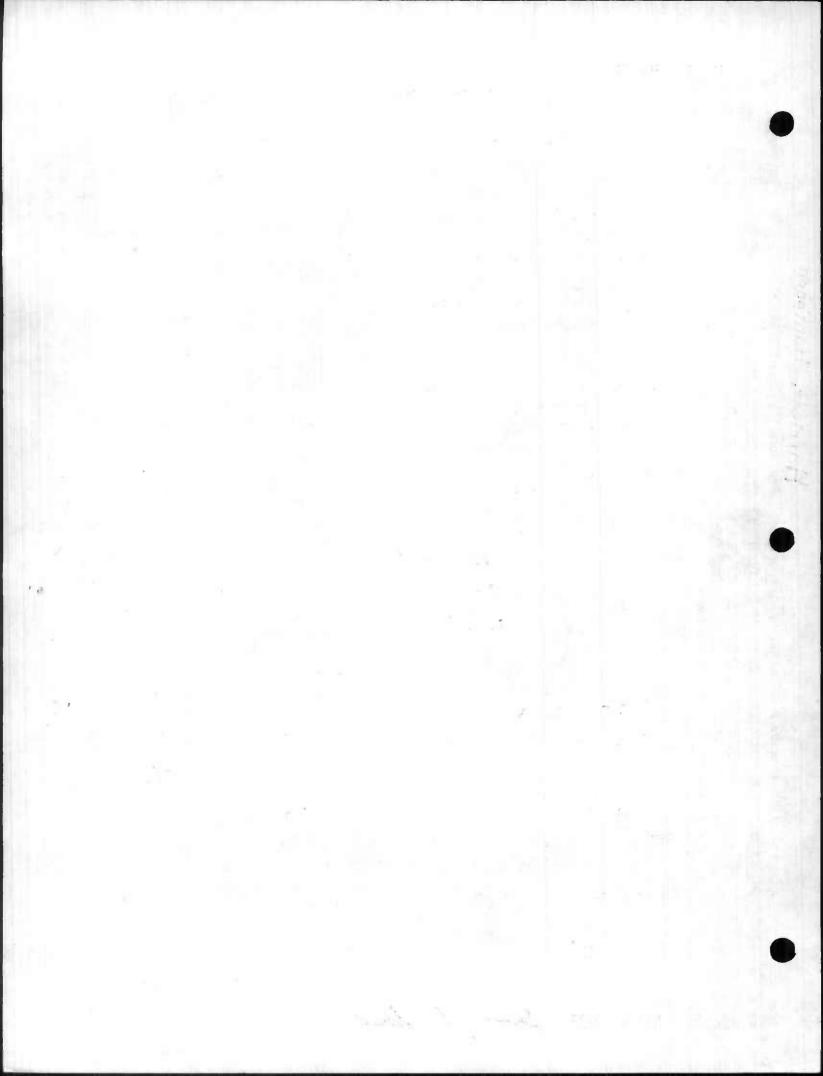
State of Maryland / Department of Health and Mental Hygiene

| | | | | | y | (| Certifica | ate of | Death | | Reg. No. | 9 | 324 | 5 |
|-------------------------------------|--|----------------------------|--|---|-------------------|------------------|-----------------------------------|-----------------------|---|---------------------------------------|------------------------------------|-----------------------------|---|----------------|
| | | | 1. Decedent's Name (First, Middle, Las | it) | | | | | | 2. Dete of D | eeth | V | 3. Time o | of Deeth |
| | Physici /Medi | | Michael Francis | Hughes | | | | | | Month APRIL | 16, 19 | 99 | 10:2 | 4 AM |
| | Examir | | 4a. Fecility Name (If not institution, give | | | | | | 4b. City, Town, or | Location of Dea | th 4c. Cour | nty of Death | | |
| | | | ST AGNES HEALTHCA | ARE 900 | CATC | N AV | ENUE | | BALTIMOR | - | | | | |
| | Funeral Director | | 210-09-4122 | ex 7. Ag | na (In yrs. 70 | last birth | Month | der 1 Yaar Is Days | | (Month, D | rth ey, <i>Year)</i> 1, 1920 | 9. Birth Cou Mary | pleca (Stete intry) Land | or Foreign |
| | pue * | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. Ci | tv. Town | or Location | | | | | | 10d. Inside C | City Limite |
| | Manyl f sho | 5 | Maryland Baltimo | 200 | | butu | | | | | | | | s 2 No |
| | the 28a | Director | 10e. Street end Number | 16 | AL | Ducu | | Zip Code | | | 10g. Citizen o | of Whet Cou | intry? | |
| | 3a o | | 1229 Leeds Terrac | | | | | 212 | 27 | | | S.A. | , | |
| 120 | death ms 2 | Funerai | 11. Marital Status unknown | 12. Wes Dacedent | Ever in U | I,S. | 13. Was Dec | | Hispenic Origin? (S sen, Mexicen, Puer | Specify Yes or N | | ace - Ameri | | |
| 020 | permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show early injury or other traumatic event, if a Medical Exercise must be notified a once. | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 XYas 2 ☐ I If Yes, Give Year or Detes: | No | | | | Specify: | to Hicen, etc.) | Spec | llack, White, | , etc. nite | |
| 5-0 | 72 ho | Completed | 15. Decedent's Ed (Specify only highest gra- | ucetion de completed) | | 16e. D | Decedent's Us | suel Occu | petion during most of wa | rkina | 16b. Kind of | Business/In | dustry | |
| 121 | vithin | mpi | Elementery/Secondery (0-12) | College (1-4or 5 | 5+) | | | | during most of wo | · · · · · · · · · · · · · · · · · · · | | | | |
| 12 | hygie her ti | | | ınknown | | t | ruck d | lrive | | (F) . A | | | rtatio | n |
| and | ntal H | Be | 17. Father's Neme (First, Middle, Last) | | | | | | 18. Mother's Ne | | | ame) | | |
| Ly. | d Me | 10 | Michael Hughes 19a. Informent's Neme/Relationship (7) | Sun - Crintl | | 105.1 | Mar Nice - Andrew | (04 | | th Grue | | 0.1.7 | 0.0 | |
| Ma | d2s than 7 is r | | | ype, Print) | | | | ess (Stree | t end Number or R | urei Houte Numi | er, City or Tow | m, Stete, Zıj | 5 Code) | |
| a) | 1 an Heal em 2 | | unknown 20a. Method of Disposition | | 20b. F | Plece of D | nown Disposition (A | leme of | - T | Dete | 20c. Location | n - City or T | own Stata | |
| 发 Baltimore, Maryland 21215-0020 | t. Peges tment of tant: If it | | 1 ☐ Buriel 2 ☐ Cramation 3 ☐ 4 ☒ Donetion 5 ☐ Other (Specify |) | (| cemetery, | , cremetory o | | | | | | | |
| Ball Ball | Depermine Depermine Important Important Information In | | / Jonami | Wada, Di | | | State Balti | Ana | ess of Fecility tomy Boar , Marylar | nd 2120 | 1 | timore | Stre | et |
| | | | 23a. Part1. Enter the diseasa, or compositock, or heart feilure. List only | lications thet caused one cause on each li | the deel | th. Do no | ot enter tha m | oda of dy | ing, such es cerdia | c or respiretory | errest, | | Approxime Intervel Be | etween |
| | Physician /Medicai Examiner | | Immediate Ceuse (Finel disease or condition resulting in death) | · Myor | Cerc | dia | l re | fa | VCTION | | | | Onset and | Deeth W } Y |
| | | - | Tooling in doding | . Myoc | Due to (| or es e co | onsequence o | of): | 2 | | | 1 | | |
| | betu | min | | | | | | | DIST | ease | | | | |
| Ć. | execting ending in ending | Exa | Sequentielly list conditions, if eny, leeding to immediata ceuse. Enter Underlying Cause (Disease or injury | | Due to (d | or es a co | nsequance o | 1): | | | | 1 | | |
| F. 68760, | death certificate be executed e attending physician end of for use es the burial-transit | Physician/Medical Examiner | thet initiated events | C | Due to (c | r es e co | nsequence of | f)· | | | | | | |
| 17 8 | tifica ig ph | Med | resulting in death) Last | | 0 10 10 10 | | | .,. | | | | į | | |
| Box | eath cer attendin I for use | 20 | | d | - | | | | | | | <u> </u> | | |
| 9 | deat | sicia | Pert II. Other significant conditions co | entributing to death b | ut not res | ulting in t | the underlying | ceuse gi | ven in Part I. | 23b. Did | tobacco use o | contribute t | to the cause | of death? |
| 20.9 | that the de led by the s detached | Phy | | | | | | | | 1 | Yas 2□No | 3 □ Pro | bably 4/2 | Unknown |
| 5, | es the igned be de | by | | | | | | | | | | | | |
| Record | The law requires that the ate has been signed by the page 2 should be detache | Completed | | | | | | | | | en eutopsy ormed? | 9/ | ere eutopsy veilable prior omplation of deeth? | to |
| | The la | Co | | | | | | | | 1 🗆 | Yes 2 No | 1 | ☐ Yes 2月 | Z No |
| hes | ysician: The sectificate director, pag | Be | 25. Wes case referred to medical exeminer? | 11 | | | | I a | 26. Place of De | eth (Check only | one) | | | |
| 0.0 | Physician: r this certificantal director, | To | 1)21 105 2 100 | Hospitel: 1 Inpatie | | ER/Outp | | DUA | | loma 5 ☐ Res | | | fy) | |
| 7 10 | tending Fleath. | lon | 27. Menner of Death 1 Natural 5 □ Pending | 28e. Dete of Injur (Month, De) | ry y Year) | 28b. Tin inju | ury | 28c. Inju Wo | | 28d. Describe | how injury occ | urred | | |
| T ois | or: | icat | 2 Accident investigation 3 Suicide 6 Could not be | One Division (Inc.) | | | М | | Yes 2 No | OOK Leasting | (01 | | - De de Al | |
| ME: Div | To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by | Certification: | 4 ☐ Homicide determined | 28e. Place of Injubulding, etc | c. (Specif | (y) | | | | City or To | (Street and Nur wn, Stata) | | | nber, |
| N/N | Hosp 14 hou Fune tely fi | edicai | Check only 2 Madical Exam | reician: To the best of inar: On the basis of | exemine | wledge, o | death occurre or investigetion | ed et the ti | me, dete end plece opinion, deeth occu | e, end due to the | date end plec | menner es s e, and dua t | stated. to the ceuser | (s) |
| | the mple | Med | 29b. Signature end title of curtiller | end manner sta | ated. | | | | se number | | 29d. Data sign | | | |
| | 7 × 7 8 | | - Sylvator S of to the State of | 7 | | | - | | 21256 | | A . | . I I | (1 C | 00 |
| | | | 30 Named Color | uno | 45 | | 5 | U | 0,0,0 | | HP2 |) (| 6,19 | 47 |
| | | | 30 Name and address of person who c | on the cause of de | eeth (Iten | n 23a) (T) | ype, Print) | A | ies H | - 1 | 1 | | | |
| | Sta | te | 31. Date filed (Manth, Dey, Yeer) | 32. Aegistre | ar's Signe | ture , | 261 | igi | 175 7 | USPITO | K 1 | | | - |
| | Registr | ar | 31. Date filed (Month, Dey, Yeer) 1990 | 1 Denes | var | 19 | 10 | - | , | | | | | |

DHMH 16 Rav 6/95

| Item# | #1 perPhyG771 5/5/99EW | State of Maryla | Certifica | | | | 99 | - Berlins | 3246 |
|--|---|--|---|--|--|-----------------------------------|--|---|---|
| Physician /Medical | 1. Decedent's Neme (First, Middle, La | Harriet Esther | Hanthorn | | | | | Year | 3. Time of Death 11:55 pm |
| Examiner | | | | 41 | b. City, Town, or Lo BALTIM | | 4c. County | of Death | |
| Funeral Director | 464-10-0359 | | 8 5 Yrs. If Unc | der 1 Year is Deys | | | | | laca (Stete or Foreign try) NOWN |
| show show | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. C | City, Town or Location | | | L | | 1 | 0d. Inside City Limits |
| with the Maryle s or 28a-f sho be notified at Director | MD N/A | BA | LTIMORE | 200 | | | 10g. Citizen of What Country? | | 1 Yes 2 No |
| 章 章 舞 百 | | | | Zip Code | | | | Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Whet County Bleck, White, Specify: WHI Bleck, White, Specify: WHI Block CHANT Action Surneme) City or Town, State, Zig City | lry? |
| of the death of the clear the same same same same same same same sam | 817 ST. PAUL S | 12. Wes Decedent Ever in | | 21202 cedent of His | | city Yes or No | Reg. No. 99 Reg. No. 99 Ite of Death 103/20 Pt 999 Ite of Death 103/20 Pt 999 Ite of Birth 104, 200 Ite of Bi | | an Indian, |
| DO 02 | 3 ☐ Widowed 4 ☐ Divorced | 1 □XYes 2 □ No | 1□ Yes | pecify Cuber 2 No | n, Mexican, Puerto Rican, etc.) | | | | |
| Hanthor 121215-0020 ad within 72 hours after striken "natural", or ha to the Medical Examina Completed by Fu | 15. Decedent's Elementery/Secondery (0-12) | | 16e. Decedent's Us (Give kind of v life. DO NOT | suel Occupa work done d use retired) | tion u <i>ring</i> most of worki | ing | | | |
| 2 1 2 1 | | 1) | SEAMAN | | 18. Mother's Neme | (First, Middle, | Reg. No. Reg. No. Reg. No. Reg. No. Reg. No. Dete of Death Mooth 3 / 20 / Pt 9 9 9 Ation of Deeth Reg. No. R | | MARINE |
| ylanc ylanc Mental H Mental H | | | ORN | | (UNKN | | | | |
| Maryland of 2 should be file the and Mental Hy 7 is marked other traumatic event traumatic event | 19a. Intermant's Neme/Reletionship | | | | | | | Para 99 Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Death Ac. County of Whet Cou U. S. A. 14. Reca - Ameri Bleck, White, Specify: WHI Ac. Kind of Business/ir Ac. County of Town, State, Zi Ac. Location - City or T BALT CON & BRO KESVILLE Ac. County of Death | |
| , <u>CEME</u> | ARTHUR L. DRA 20a. Method of Disposition | | | | T #510B | | | | |
| altimore, mit. Papes 1 s partiment of the partiment of th | 1 XBurial 2 Cremetion 3 [4 Donetion 5 Other (Special | Removel from State (fy) | SHE EMUNA | AH AI | TZ CHAI | | | | IMORE, MD |
| Ban Desmi Desmi Bany to anno a sany to a sany | SCOTT M. C | UTTLER | 89001 | REIST | SOL | ROADI | PIKESVI | | |
| Physician | 23a. Pert1. Enter the diseese, or con shock, or heert tailure. List only | nplicetions thet caused the de- one ceuse on each line. | eth. Do not enter the m | ode of dying | g, such es cardiec d | or respiretory e | rrest, | | Approximete Intervel Between Onset and Death |
| /Medical Examiner | Immediete Ceuse (Final diseese or condition resulting in deeth) | Ine/Reletionship (Type, Pnint) L. DRAGER/ATTORNEY SLIGHT STREET #510BALTIMORE, MD 212 District on 1 State | <1 NC | | | | | | |
| P.O. Box 68760, sat the death certificate be executed by the attending physician and stached for usa as the burial-transit Physician/Medical Examiner | Cause (Disease or injury that infleted events resulting in death) Last | The (First, Middle, Last) HANTHORN HOSPITAL CORPORATION Number 6. Sex 1 M 2 F 7. Age (in yrs. last birthdey) 1 Decedent 1 10c. County 1 M 2 F 1 Decedent 1 10c. County 1 Decedent 1 Decedent 1 Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex of Decedent Sex or Obeles: WWII 1 Sex or Obeles: WWII 1 Sex or Obeles: WWII 1 Sex or Obeles: WWII 2 Sex or Obeles: WWII 2 Sex or Obeles: WWII 3 Sex or Obeles: WWII 4 Sex or Obeles: WWII 5 Decedent's Education Sex or Obeles: WWII 5 | (or es e consequenca o | rt): | A71 | 14.65 | | | YM |
| that the destroy the at detached for | Pert ii. Other significant conditions | contributing to death but not re | sulting in the underlying | g cause give | n in Pert i. | | | | 00 |
| S, P. ss that t se that t be detail by Ph | Dani | D.T.S | | | | 10 | Yes 2□ No | 3 Pro | pably Volknown |
| aw requires been size been size been size pleted | Ansu | 4 | | _ | | 24a. Wes | en eutopsy / | av | ere eutopsy findings eilable prior to mpletion of cause death? |
| The if | | | | | | 10 | Yes 2000 | 10 | Yas 2□ No |
| of Vital Physician: The this certificate rail director, page 1: To Be Co | 25. Was case referred to medical exeminer? | Hospitel: | 750000000000000000000000000000000000000 | Othe | 26. Place of Deeth | | | | |
| After fune | 27. Menner of Death | 28e. Dete of Injury (Month, Dey Year) | 28b. Time of | 28c. Injury Work | 41 Jursing Ho | | | | γ) |
| × 9492 | 3 Suicide 6 Could not to determined | 200. Pleca of injury - At | home, ferm, street, tect- | ory, office | | 28f, Location (City or Ton | Street end Numb wn, Stete) | er or Rura | l Route Number, |
| To the Hospital or within 24 hours after completely filled in Medical Cert | (Check only 2 Medicat Example) | miner: On the basis of examin | owledge, deeth occurre letion end/or investigetion | ed et the tim on, in my op | e, date end plece, e inion, deeth occurre | end due to the ed at the time, | cause(s) end me date end piece, a | nner es s and due to | ated. the cause(s) |
| To within To the Common | 29b. Signeture and title of certifier | | 2 | D 2 | NW 6 | | 29d. Date signed | (Month, | Day, Year) |
| | Scalia, Simon M | D Future Car | re-Canton H | arbor | 1300 S. | Ellwood | l Avenue | Stitzen of Whet Country) 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Citizen of Whet Country? 10d. Inside 112 Ye Country WHITE Kind of Business/Industry RCHANT MARI In Sumeme) 10d. Inside 112 Ye Country WHITE Country WHITE Country WHITE Country Town, State, Zip Code) 10d. Marian 10d. Inside 112 Ye Country WHITE Country WHITE Country Town, State, Zip Code) 10d. Marian 10d. Inside 112 Ye Country WHITE Country | |
| State Registrar | 31. Date tiled (Month, Dey, Year) APR 2 2 1999 | 32. Registrer's Sign | G. Look | 2 | | | | | |

DHMH 16 Rsv 6/95



State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year) APR 2 2 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

20b. Signature and title of certifie

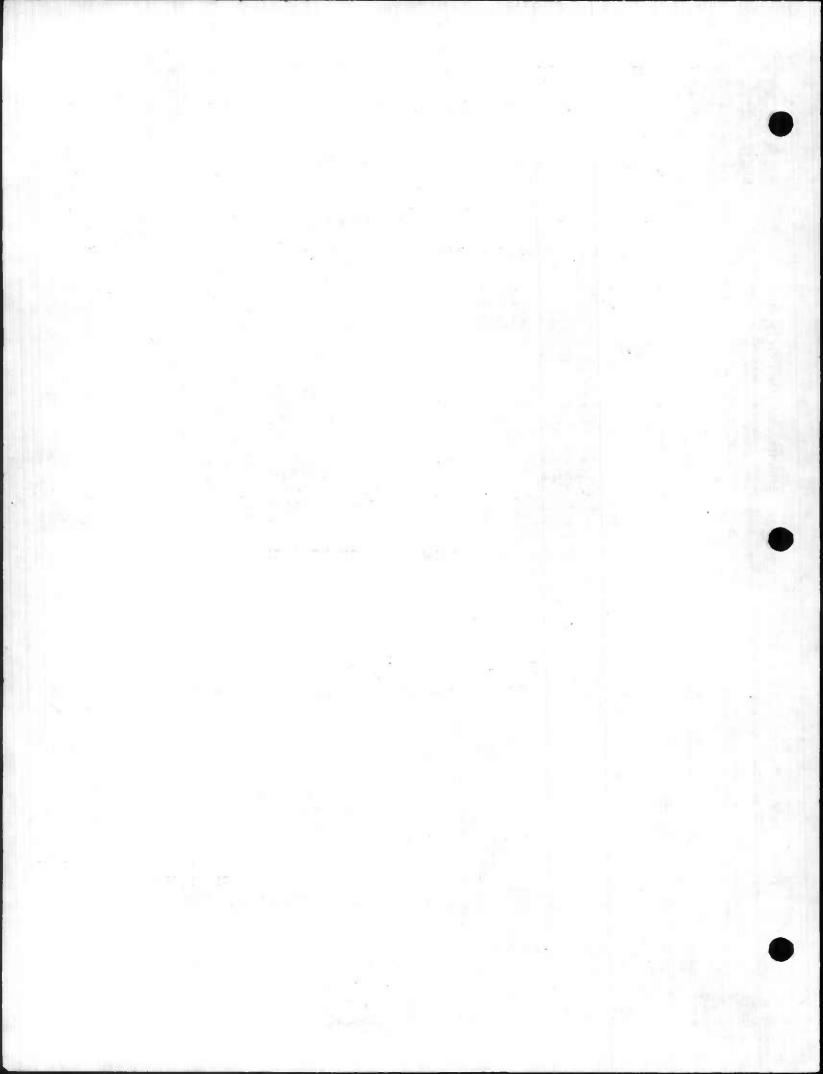
111 Penn Street, Baltimore, Maryland 21201 32 Alegistrar's Signature

29c. License number

O.C.M.E.

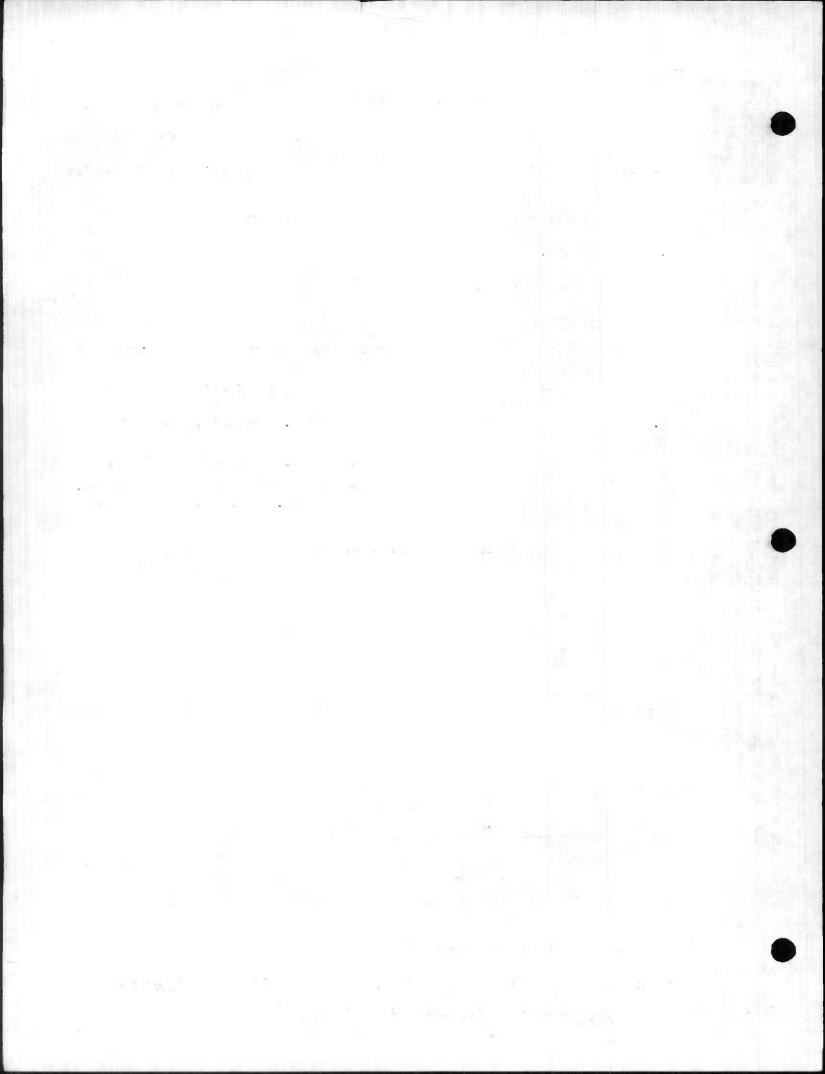
29d. Date signed (Month, Day, Year)

April 17, 1999

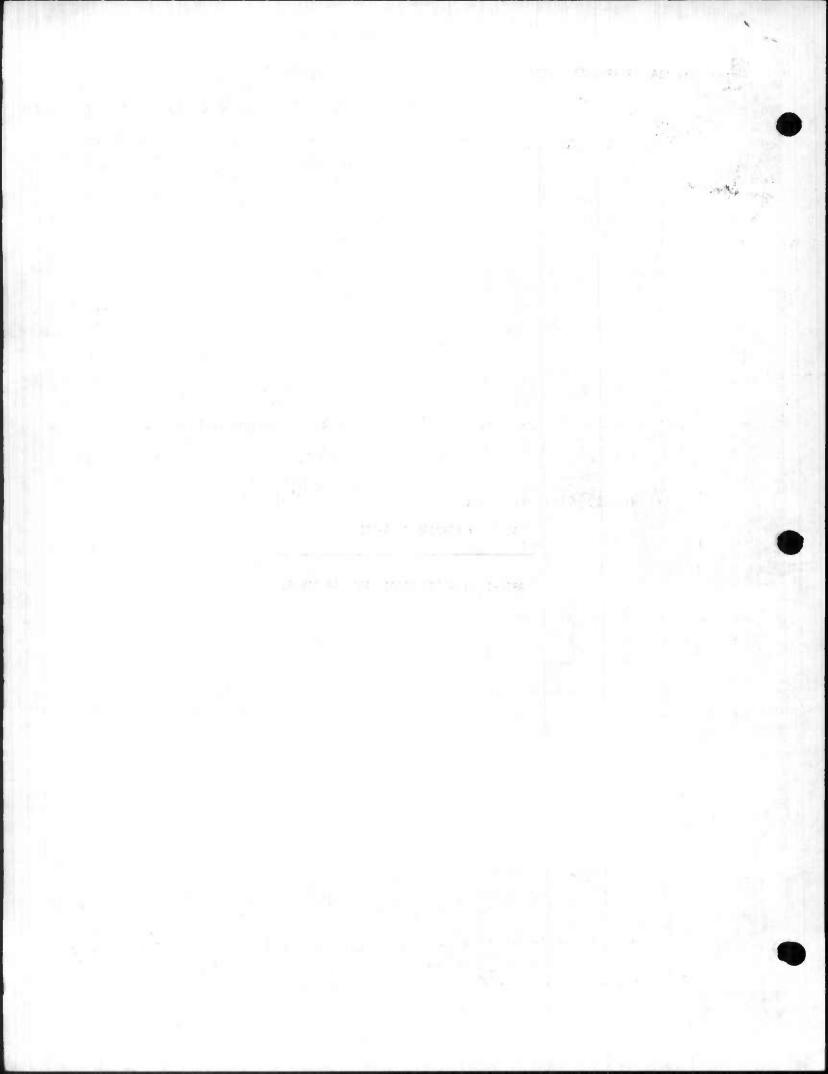


DHMH 16 Rev 6/95

ORIGINAL



| Ameno | ded# | 23apt1A-B 1. Decedent's Na | | | 99 EW | | Cei | rtificate o | f Death | 2. Dete of [| Reg. No. | | 3. Time of Deal |
|--|--|--|--|-----------------------------|--|--|--|--|---|---|--|--|---|
| Physic /Medi | | | | | - | 100 | RE | HUK | | Month | L Day | 1990 | 3. 1 me of Deal |
| Exami | ner | 4a. Facility Neme 45. Social Security | new | on, give street | 1 6 | El | VES, | /S | BAIT | or Location of Del IMORE | B | ALT | Imore |
| uneral irector | | 220-03-25 Usual Residence | 51 | 1 M | | 92 | Yrs. | Months Day | | Min. (Month, I | 3, 1906 | Co | hplace (State or For untry) Sylvania |
| 28a-f show | - o | 10a. State Maryland | 10b. County | | | | 10c. City, Town or Location Baltimore County | | | | | | 10d. Inside City Lin 1 ☐ Yes 2 |
| | | | | | | Dai | . wible (| 10f. Zip Code 21234 | | | 10g. Citizen o | of What Co | ** |
| at', or items 23 | 11. Marital S | | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates: | | | | | Was Decadent of | ıban, Mexican, P | ? (Specify Yes or f uerto Rican, etc.) | No- 14. R | llack, White | rican Indien, a, etc. |
| | (Sp Elementery/Se | ecify only highe | | npleted) college (1-4or | 5+) | 16a. Deced (Give life. L | | upation e during most of red) | working | 16b. Kind of | Business/I | Industry | |
| s marked other than sumatic event, the | To Be Co | 17. Fether's Nem | e (First, Middle, lphewstei | 117 | | | Totaledo | <i>-y</i> | 18. Mother's Julia I | Name (First, Midd Jaknown | | Maryland Railroa ame) | |
| important: if item 27 is marked other than "natu any injury or other traumetic event, the Magical ance. | | 20e. Method of D 1 □ ₩Burial | hlumsky Isposition | (Grandda | anddaughter) 2605 Canterbury Road Baltimore, Maryland 2123 20b. Place of Disposition (Neme of commetery, crematory or other place) 20c. Location - Commetery, crematory or other place) | | | | | | 23/4 n - City or 1 | Town, State | |
| sician edical | | Illinediale Ceuse | 9 (FIII8) | r complication only one cau | ns that cause use on each I ACUTE | d the deat ine. MYOCA | th. Do not ente | SSANN FUN O1 Belair or the mode of d FARCTION | eral Home, Road Bali ying, such as car | Inc. | yland 212 arrest, | 236-462 | Approximete Interval Betwee Onset end Dear |
| edical miner ial-transit | ledical Examiner | 23a. Pert1. Enter shock, or he shock, or he disease or conditions and the suiting in death sequentially list of any, leading to cause. Enter Uncause (Disease of that initiated ever resulting in death | conditions, immediate derlying or injury | r complication only one can | 160 | Due to (d) SCL ER | th. Do not enter | O1 Belair of the mode of de FARCTION uence of): DIOVASCUL/ uenca of): | eral Home, Road Ball ying, such as car AR DISEASE | timore, Mar diac or respiratory | yland 212 arrest, | 236-462 | Approximete Interval Betwee Onset end Deat |
| gned by the attending physician and upper detached for use as the burial-transit to the contract of the contra | by Physician/Medical | Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever | conditions, immediate derlying or injury its | a b c d | ARTERIO | Due to (c) SCL ER Due to (c) | th. Do not enter RDIAL IN Cor as a consequence of the correct | O1 Belair or the mode of dy FARCTION uence of): DIOVASCUL/ uence of): uence of): | Road Ball ying, such as car AR DISEASE | diac or respiratory | d tobacco use d ⊇Yee 2□No | contributa 3 □ Pro | to the cause of de |
| hes been signed by the attending physician and up to should be detached for use as the burial-transit | by Physician/Medical | disease or conditing in death resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease that initiated ever resulting in death | conditions, immediate derlying or injury its | a b c d | ARTERIO | Due to (c) SCL ER Due to (c) | th. Do not enter RDIAL IN Cor as a consequence of the correct | O1 Belair or the mode of dy FARCTION uence of): DIOVASCUL/ uence of): uence of): | Road Ball ying, such as car AR DISEASE | diac or respiratory 23b. Di 10 24a. Wa | d tobacco use o Yee 2□ No as an autopsy formed? | contributa 3 □ Pr | to the cause of de obebly 4 Unk Were autopsy findir invallable prior to completion of cause of death? |
| ate hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit of the bage 2 should be detached for use as the burial-transit of the bage 2 should be detached for use as the burial-transit of the bage 2 should be detached for use as the burial-transit of the bage 2 should be detached for use as the burial-transit of the bage 2 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use as the burial-transit of the bage 3 should be detached for use 3 shou | Be Completed by Physician/Medical | disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause. (Disease that initiated ever resulting in death Pert II. Other eign 25. Was case refe exeminer? | conditions, immediate derlying or injury its | a | ARTERIO | Due to (c) SCL ER Due to (c) | th. Do not enter RDIAL IN Cor as a consequence of the correct | O1 Belair of the mode of de FARCTION Usence of): DIOVASCUL usence of): usence of): usence of): | Road Ball ying, such as car AR DISEASE given in Part I. | diac or respiratory 23b. Di 10 24a. Wa | d tobacco use of Yee 2 No | contributa 3 □ Pr | to the cause of de obably Were autopsy findir visilable prior fo completion of cause |
| Affer this certificate has been signed by the attending physician and University page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 2 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use as the burial-transity of the page 3 should be detached for use 3 should be de | To Be Completed by Physician/Medical | disease or condit resulting in death disease or condit resulting in death services of the cause. Enter Unicause, [Disease that initiated ever resulting in death services of the cause of t | conditions, immediate deriving or injury its) Last | a | ARTERIO | Due to (constitution) Due to (constitution) Due to (constitution) Due to (constitution) | th. Do not enter RDIAL IN Cor as a consequence of the correct | O1 Belair or the mode of dy FARCTION Usence of): DIOVASCUL usence of): usence of): deriving cause of 28c. Inj | Poord Ball ying, such as can AR DISEASE given In Part I. 26. Place of ther: 4 (D Nursin | 23b. Di. 24a. War per Locath (Check only) | d tobacco use of Yee 2 Notes an autopsy formed? | contributa 3 Pr 24b. Ve | to the cause of de obably Unk Were autopsy findir vallable prior fo completion of cause of death? |
| ctor: Affer this certificate hes been signed by the attending physician and Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 3 should be detached for use as the burial-transit of Spanial director, page 3 should be detached for use as the burial-transit of Spanial director, page 3 should be detached for use as the burial-transit of Spanial director dire | Certification: To Be Completed by Physician/Medical | disease or condit resulting in death disease or condit resulting in death services of the cause. Enter Unicause (Disease that initiated ever resulting in death services of the cause of th | conditions, immediate derlying or injury sits) Last | d | ARTERIO | Due to (c) SCL ER Due to (c) Due to (c) Due to (c) Pue to (c) Due to (c) | th. Do not enter RDIAL IN Cor as a consequence or 1 Belair or the mode of dy FARCTION Usence of): DIOVASCUL usence of): usence of): usence of): deflying cause of 28c. Inj W net, factory, office | Poad Ball ying, such as car AR DISEASE given In Part I. 26. Place of Nither: 4 D Nursin ury at ork? Yes 2 \(\) No | 23b. Didiac or respiratory 23b. Didiac or respiratory 24a. Wa per 1 Death (Check only 19 Home 5 Be 28d. Described 28f. Location City or T. | d tobacco use of Yee 2 Notes an autopsy formed? Yes 2 Notes and Yes 2 Notes and Notes | contributa 3 Pr 24b. V 6 C C Dither (Specurred | to the cause of de obably 4 Unk Were autopsy findin viallable prior fo completion of cause of death? Yes 22 No |
| ctor: Affer this certificate hes been signed by the attending physician and Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 2 should be detached for use as the burial-transit of Spanial director, page 3 should be detached for use as the burial-transit of Spanial director, page 3 should be detached for use as the burial-transit of Spanial director | edical Certification: To Be Completed by Physician/Medical | disease or condit resulting in death disease or condit resulting in death services and the services of the cause. Enter Unicause (Disease of that initiated ever resulting in death services) and the services of the cause of the | conditions, immediate deriying or injury its of the condition of the condi | b | ARTERIO ARTERIO ing fo death be all line and line and line (Month, Da bet of Inju (Month, Da building, et line and line building, et line best line and line and line building, et line best line and l | Due to (constitution of examina | th. Do not enter RDIAL IN Cor as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of as a consequence of a consequence | O1 Belair or the mode of def FARCTION Usence of): DIOVASCUL usence of): usence of): usence of): and or in the mode of def a | Poad Ball ying, such as car AR DISEASE given in Part I. 26. Place of other: 4 D Nursin ury at ork? Yes 2 No | 23b. Di. 24a. War 24a. Wa 25b. Di. 24a. Wa 25c. Describe 28d. Describe 28f. Location | d tobacco use of Yee 2 Notes an autopsy formed? Yes 2 Notes | contributa 3 Pr 24b. V 24b. V Contributa Contribu | to the cause of de obebly I Unk Were autopsy findin vallable prior fo completion of cause of death? Yes 2D No cause of death? |
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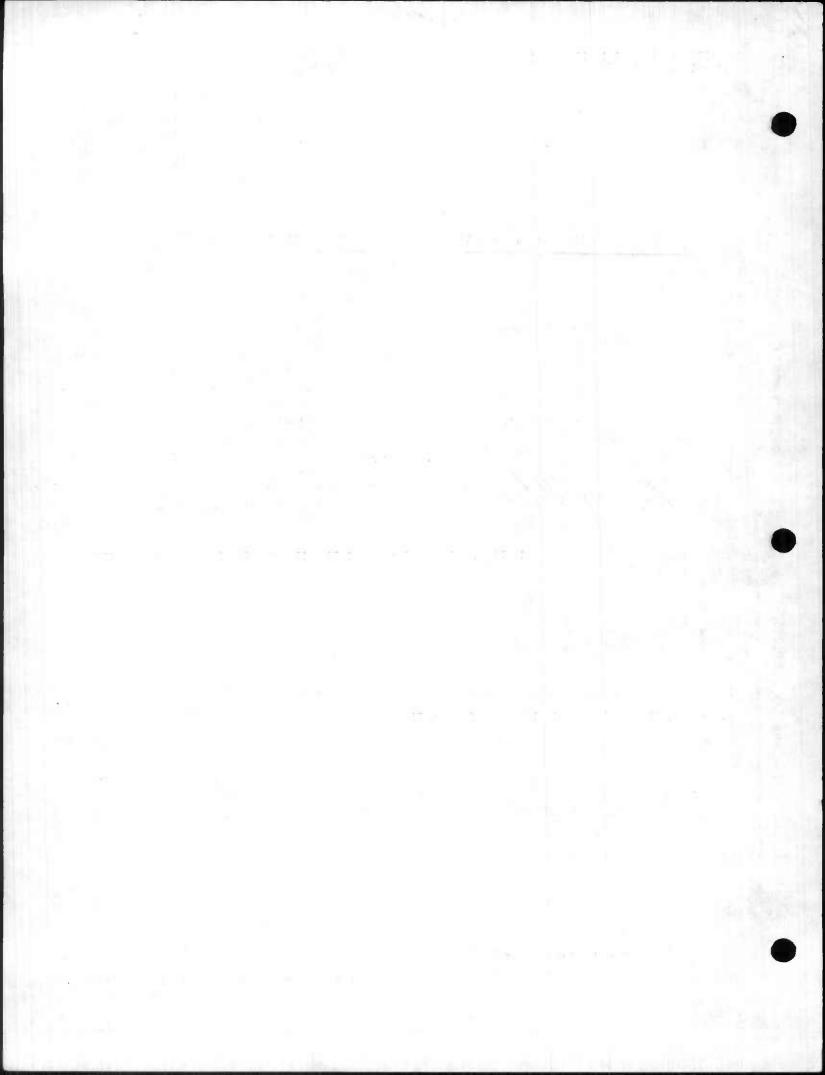
| 3-11 | | | | | |
|------|---------------------------|------------|--|----------------|-------|
| elen | Horton ITEMS: #23 PART I. | II. 27 PFR | of Maryland / Department of Health and Men Certificate of Death | ital Hygiene a | 13250 |
| | Item#10e-f perFH G770 | 4/22/99 EW | Certificate of Death | Reg. No. | 10200 |

| en Horton Ite | em#1 | MS: #23 PART I, II, lOe-f perFH G770 4/22 | /99 EW | 4 =23- | er Cer | tificate | e of L | Death | | | g. No. | 1 3 | 200 |
|--|-----------------|--|--|---------------|----------------------|------------------------|-------------------|--|--------------------------|---|------------------------|------------------------------------|--|
| Dhuaia | ion | 1. Decedent's Neme (First, Middle, | Last) | | | | | | | Dete of Death Month | Day | Year 3. | Time of Death |
| Physic: /Medi | | Helen Jeanet | | | | | | | Ag | oril 1 | | 9 8 | :10 A.M. |
| Exami | ner | 4a Facility Name (If not institution, | give street and number) | | | | 4 | b. City, Town | , or Locatio | n of Death | 4c. County | of Deeth | |
| 4 | | 111 West Mulber | | | | Milladas | 1 V-01 | Balt If Under 24 | imore | | N | | |
| Funeral Director | | 5. Social Security Number 218-64-0086 Usual Residence of Decedent | . Sex 7. Age (| In yrs. lasi | t birthday) | If Under Months | Days | | Min. (| Date of Birth Month, Day, 7 / 1 0 / | Year) 1957 | 9. Birthplace Country) Mary] | (Stete or Foreign Land |
| Pu k | | 10a. Stata 10b. County | 1 | Oc. City, T | own or Lo | cation | | | | | | 10d. I | nside City Limits |
| Mary | ō | Md. N/A | A | Ва | ltim | ore | Cit | У | | | | 1 | Yes 2□No |
| 3a or 28a | i Directo | | West Mulberry S | t | | 101. Zip | | 2120 | 1 | 10 | U.S. | What Country? | |
| d within 72 hours after death with the Manyland glens. If than "natural", or flems 23a or 28a-f ahow in than "natural", or flems 23a or 28a-f ahow in the Medical Learning man be notified. | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | er in U,S. | | Ves Deced Yes, spec | | spanic Origin n, Mexican, P Specify: | ? (Specify verto Rica | Yes or No- n, etc.) | Bled | e - American Ir ck, White, atc. | |
| 72 ho | pete | 15. Decedent's (Specify only highest) | Education completed) | 1 | 6a. Deced | lent's Usua | l Occupe | ation furing most of | working | 1 | 6b. Kind of Bu | usiness/Industr | у |
| | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | life. L | OO NOT us | e retired |) | | | | | |
| Hygier Cher th | | 12th | - 1 | | D | isab | led | 40.00.0 | A1 200 | | | MOW | ~ |
| semit. Peges 1 and 2 should be filed within 72 hours. Department of Heelth and Mental Hygiena. mportant: if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Paca. | To Be | 17. Father's Name (First, Middle, La Woodrow Horto | on | | | | | Hele | n C. | Mack | | | |
| 2 sh land | | 19a. Informent's Name/Relationship | | | 19b. Mailin | g Address | (Street i | and Number of | or Aural Ro | ute Number, | City or Town, | Stere, Zip Coo | yland |
| s 1 and if Health Item 27 other tr | | Helen C. Horto | on/Mother | | | iN . | | gwood | | , Dal | On Leasting | City or Town, | 216 |
| permit. Pages 1 sr Department of Hee Important: If Item 2 eny injury or other phos. | | 20a. Method of Disposition 1 Durial 2 Cremetion 3 4 Donation 5 Other (Spe | | CBITT | etery, crem | natory or of | her plec | _{e)} Park | | | | lawn, | |
| Physician /Medical Examiner | J. | 25a. Pert1. Enter the disease, or or shock, or heart failura. List or Immediate Cause (Final disease or condition resulting in death) | a. DILATED CAR | RDIOMY | | ASSOC | | | | | | | 3 2121° proximate urval Between set end Deeth |
| death certificate be executed a stending physician and of for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b Due to (or as a consequence of): c Due to (or as a consequence of): | | | | | | | | | | |
| stending f | 2 | | d | | | _ | | | | | | | |
| the the | Physician/M | Part II. Other significant conditions SCHIZOPHRENIA, DEPR | | | | derlying or | eusa give | en in Part I. | | | s 2 No | ntribute to the | causa of death? |
| requires been sign should be | Completed by | | | | | | | | | 24a. Wes ar perform | | availab | autopsy findings le prior to stion of cause th? |
| | Eo | | | | | | | | | N ⊋Ye | s 2 No | DELYO | s 2 No |
| | | 25. Was case referred to medical | T | | | | | 26. Place of | Death (C) | eck only one | | | |
| Physician: this certific ral director, | To B | examiner? 1 ⊠ Yes 2 □ No | Hospital: | 2□ER | /Outpatien | 3 DO | A Oth | or. | | | nce 6 Oth | er (Specify) | |
| ang Affect Inne | | 27. Manner of Death 1 🖾 Natural 5 🗀 Pending 2 🗀 Accident investigat | 28a. Data of Injury (Month, Day Y | 28 | b. Tima of Injury | | Bc. Injun Work | | 28d. | A | w injury occur | | |
| | Certification: | 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) | | | | | , office | | 28f. | Location (Str City or Town | eet end Numb Stete) | per or Rural Ro | ute Number, |
| he Hospital or in 24 hours afti he Funeral Dit pietely filled in | edical | | Physician: To the best of manner: On the basis of an and manner state | camination | | | | | | | | | |
| A C Y X | - | mm | | | | 200 | Linnan | number | | 1 20 | 4.0-1 | | |
| within 24 ho within 24 ho To the Fun completely | Σ | 29b. Signature and titte of certifier | Mits | | | 290 | Licerise | TIGHTIDOL | | 20 | d. Date signe | d (Month, Day, | Year) |

State Registrar

ted cause of death (New 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** 5-20 PM APRIL 1999 18 Ruth Anne Justin /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 F **Funeral** Months Yrs. 78 **Director** 159-14-9472 March 08, 1921 Washingtion, PA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo SD Brown Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 57401 810 2nd Avenue. USA Funeral 72 hours after death 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Nevar Married 2K Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0020 If Yes, Give Yaar or Dates: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Hygiena. Etamantary/Secondary (0-12) Collega (1-4or 5+) BookKeeper Clothing Store 18 Mother's Name (First Middle Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lujury or other treumatic event plose. Wylie Iams Annie Laurie Steele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Russell Justin/ Husband 810 2Nd Avenue. Aberdeen, SD 57401 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition cemetery, crematory or other place)
Sunset Memorial Gardens 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4/23/99 Aberdeen, SD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home Inc. 21. Signature of Funeral Service Licenses 736 Edmondson Ave. Catonsville, MD21228 23a. Part1. Enter tha disease, or complications that causad tha daath. Do not enter the mode of dylng, such as cerdiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Physician METASTATIC OVARIAN CANCER /Medical Immediate Cause (Final 6 MONTHS disease or condition resulting in daath) Examiner Dua to (or as a consequance of) Examiner attanding physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated exects.) Due to (or as a consequence of): Box 68760 Physician/Medical that initiated evants rasuiting in daath) Last Due to (or as a consequance of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the g DISEASE 1 Yes 2 No 3 Probably 4 Unknown LUNG CHRONIC OB STRUCTIVE signed t Division of Vital Records, à 24b. Were autopsy findings avaitable prior to completion of cause of daeth? 24a. Was an autopsy performed? Completed peen has 1 Yes 2 No 1 Yes 2 →No certificate Programs after dearn.
24 hours after dearn.
In py the funeral director. or Attending Physicien; after death. Be 25. Was casa raferrad to medical examinar? 26. Place of Death (Check only ona) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 \ Homicida edical 29a. Certifie 12 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifier Yal

State Registrar

31. Date filed (Month, Day, Year) APR 2 2 1999

M. SHIRAZI, M.D. NORTH ARUNDEL 32. Registrar's Signatura

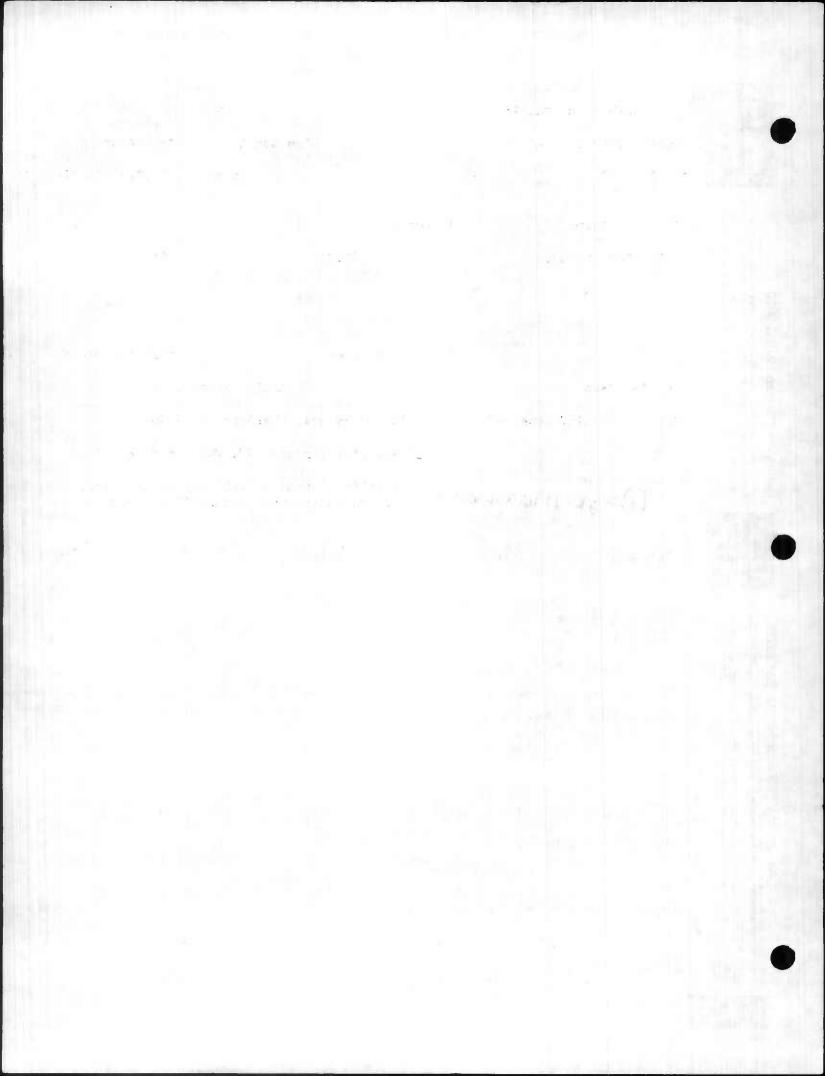
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

HOSPITAL. MD 21061. garker

D46962

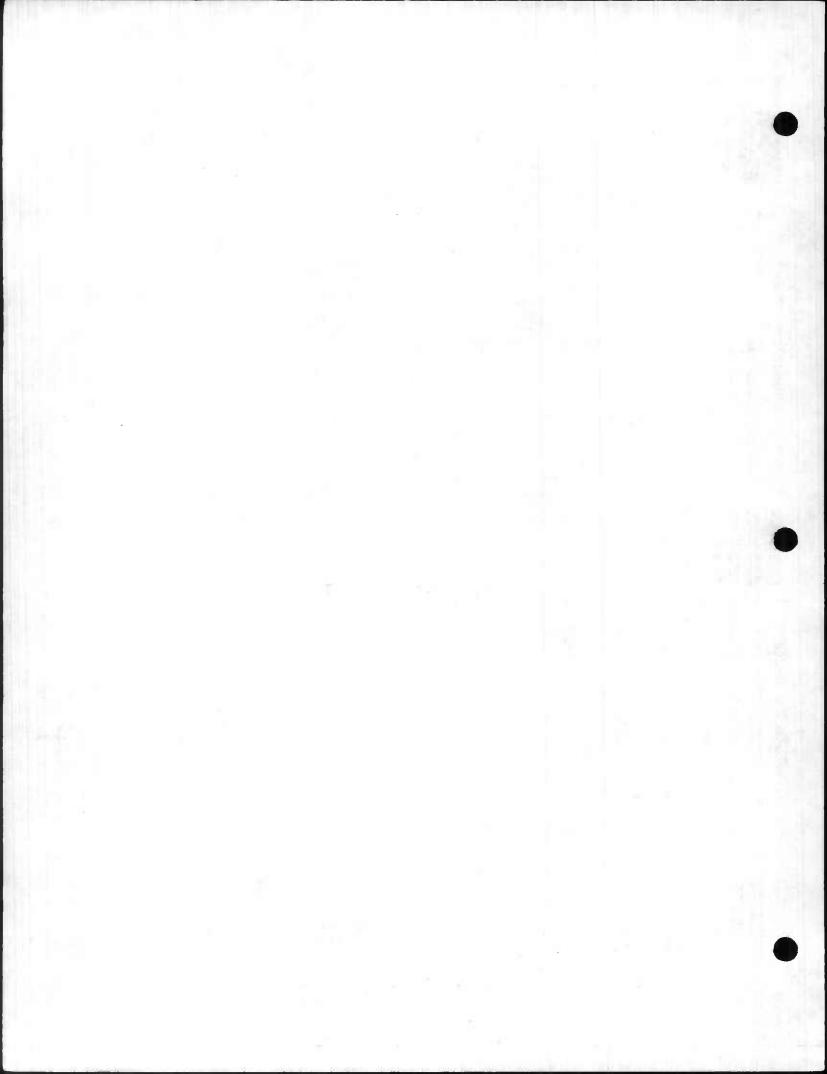
APRIL 18, 1999.

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

| | | | | Certific | ate of | Death | | eg. No. | 9 13 | 252 |
|--|--|--|-------------------------------|------------------------------|---|---|--|----------------------------------|--------------------------------------|--|
| Physician /Medical | Decedent's Neme (First, Middle, La MILDRED | | | | | LEIN | 2. Date of Dea Month APRIL | 20, 19 | Yaer 99 4 | :45 AM |
| Examiner | 4a Facility Nama (If not institution, giv 12208 MORNING L | | CE | | | 6b. City, Town, or L GAITHER | | 4c. County | | |
| Funeral Director | 033 10 3103 | ex 7. Age | (In yrs. last bir | | nder 1 Year ths Days | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day, APR - 7 | Year) 1920 | | Stata or Foreign |
| filed within 72 hours after death with the Maryland thysiene. thysiene. ther than "natural", or items 23s or 23s-1 show out, the Medical Examiner must be notified at a Completed by Funeral Director. | Usual Rasidence of Decedanf 10a. Stata 10b. County | | 10c. City, Town | n or Location | | | | | | sida City Limits |
| | NY BRO | ONX | RIVERD | | 75 Ondo | | | 0= 000=====41 | | Yes 2 No |
| | 3530 HENRY HUDSO | N PARKWAY | - APT. | | . Zip Code | 10463 | | U.S.A | What Country? | |
| | 11, Maritel Stafus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas: | | | ecedent of I- specify Cubi is 2X No | lispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | ce - American Ind ck, White, atc. | otien, WHITE |
| | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | 16a. | Decedent's I | Jsual Occup work done | ation during most of work d) | ing | 16b. Kind of B | usinass/Industry | |
| | Elementary/Secondary (0-12) | College (1-4or 5- |) 2 P | PROPRIETOR | | 3) | | PARKI | NG GARAC | GES |
| I SE | 17. Father's Nama (First, Middle, Last) HYMAN | | v | ATZ | | 18. Mother's Nam | a (First, Middle, I | Maiden Sumen | | |
| and Mental s marked o aumatic ev | 19e. Informant's Name/Relationship (| | | ress (Street | ROSE and Number or Rui | al Route Number | City or Town. | MOST State, Zio Code | e) | |
| Health a em 27 is om 27 is other tran | SHERON ROSEN / | ** | 1 | 2208 M | ORNIN | G LIGHT T | | | | |
| permit. Pages I Department of He important: If flen any injury or oth pncs. | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 💆 4 ☐ Donetion 5 ☐ Other (Specifi | | 20b. Place of cemater BETH I | y, cremetory | or other plac | , | Date 4/21/99 | | City or Town, S | tate |
| Departri Importa any inju | 21. Signature of Futbral Service-Licen | 1590 | | | | ss of Facility ISTERSTOW | SOL LE | VINSON | & BROS | |
| rificate be executed by physician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Que to (or as a co | consequence | of): | | | | | |
| y the attending sched for use a hysician/M | | d | | | | | | | 1 | |
| 2 2 2 | Part II. Other significant conditions of | ontributing to death bu | t not rasulting in | the underlyi | ng causa giv | en in Part I. | | es 2 No | ntribute to the o | (. |
| 2 should | | | | | F | | 24a. Was a perfori | | evailable | atopsy findings a prior to ion of cause ? |
| certificate har rector, page | | | | | | | 1 🗆 Yı | s 2 No | 1 ☐ Yes | 2 No |
| 9 0 | 25. Wes case referred to medical examinar? 1 | Hospitel: 1 Inpatier 28a. Data of Injury (Month, Day) | 28b. T | | 28c. Injur Wor | 4 LI Nursing Ho | h (Check only on oma 5 Reside 28d. Describe ho | enca 6 XOth | er (Specify) RE | AUGHTER ESIDENC |
| To the Popular of Antendria Privile Within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Inju- building, atc. | ry - At homa, fa (Specify) | rm, street, fac | ctory, office | | 28f. Location (SI City or Town | reet and Numb n, Steta) | per or Rural Rou | te Number, |
| within 24 hours a To the Funeral I completely filled | 29e. Certifier (Check only one) 2 Medical Example 2 | ysician: To the best of liner; On the basis of a and mannar stat | examinetion and | deeth occur Vor investiga | red et the tin tion, in my o | ne, data and plece, pinion, deeth occur | and due to tha cred at tha tima, d | ouse(s) and ma ate and plece, | anner as stated. and due to the c | ause(s) |
| withir Toth comp | 29b. Signatura and titla of certifier NEUD. K | Pavin 1 | nD | | 29c. Licens | 26704 26704 | (m))2 | 9d. Date signe | d (Month, Day, | rear) |
| 7 | 30. Name and address of person when NEILD. | KTIVIN | 5530 | Type, Print) | Cons | Sy A | NUEC | 18504 C | HASEM | 02081 |
| State Registrar | 31. Defe filed (Month, Day, Year) 2 | 1999 32. Regisfra | s Signature | p. | papar | W | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath KEILBAR 2:20 PM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath BALT MORE If Undar 24 Hrs. 8. Data of Birth Month, Day, Yaer FEB. 12, 1908 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number Months Days Yrs. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nas 2 No MD. BALTIMORE 10a. Streat and Numbar 10f. Zip Coda 10g. Citizan of What Country? S. DECKER AVE. U. S.A 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 No if Yas, Give Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Navar Marriad 2 ☐ Marriad Specify: 3 Widowad 4 □ Divorced WHITE 15. Decedent's Education (Specify only highast grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) GENERAL MOTORS MAINTENCE 17. Father's Nama (First, Middla, Last) JOHN KEILBAR CLARA E. LORING 19a. Informant's Name/Ratationship (Typa, Print) 19b. Mailing Addrass (Street end Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) FR. GERARD SZYMKOWIAK 505 WOOD CREST AVE. 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Bunal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donetion 5 □ Othar (Spacify) 1999 BALTO. MD 21. Signature of Euneral Service Licensee 2829 HUDSON ST 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death ELECTROLYTE IMBALANCE Immadiata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): DIZ(+YDRATIE Sequantially list conditions, if any, laading to Immadiata cause. Entar Underlying Causa (Disaasa or Injury that Initiated evants rasulting in deeth) Last Dua to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SCLB NOSIS 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? 1 Yas 2 No 1 Yas 21 No 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☑Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No 28b. Tima of

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours electdeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnel-transit P.O. Box 68760, Records, Division of Vital

Examiner Physician/Medical Be Completed by Medical Certification: To

Physician

/Medical

Examiner

Director

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Director

leath and Menta Hygiens. nr 2th tentament other than "natural", or items 23e or 28e-f show ther traument event, the Medical Examiner must be notified at

MORE AMOUNDED STRIGGODD

1 and 2 should be 1 Health and Mental

t. Pages tment of h

injury or

Physician

/Medical

Examiner

27. Manner of Death

1 Natural 2 Accidant 3 Suicida 4 Homicide

5 Pending invastigation 6 Could not be detarmined

28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

CHURCH HOSPITAL, BALT. M.D.

28f. Location (Straat and Number or Flural Flouta Number, City or Town, Stata)

29a. Certifiar

1 Certifying Physician: To tha best of my knowladga, daath occurred at the tima, data and placa, and dua to tha causa(s) and menner es stated.
2 Medical Examiner: On tha basis of examinetion and/or invastigetion, in my opinion, daath occurred at the time, data and place, and dua to tha causa(s) and mannar statad.

29b. Signature and titla of certifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

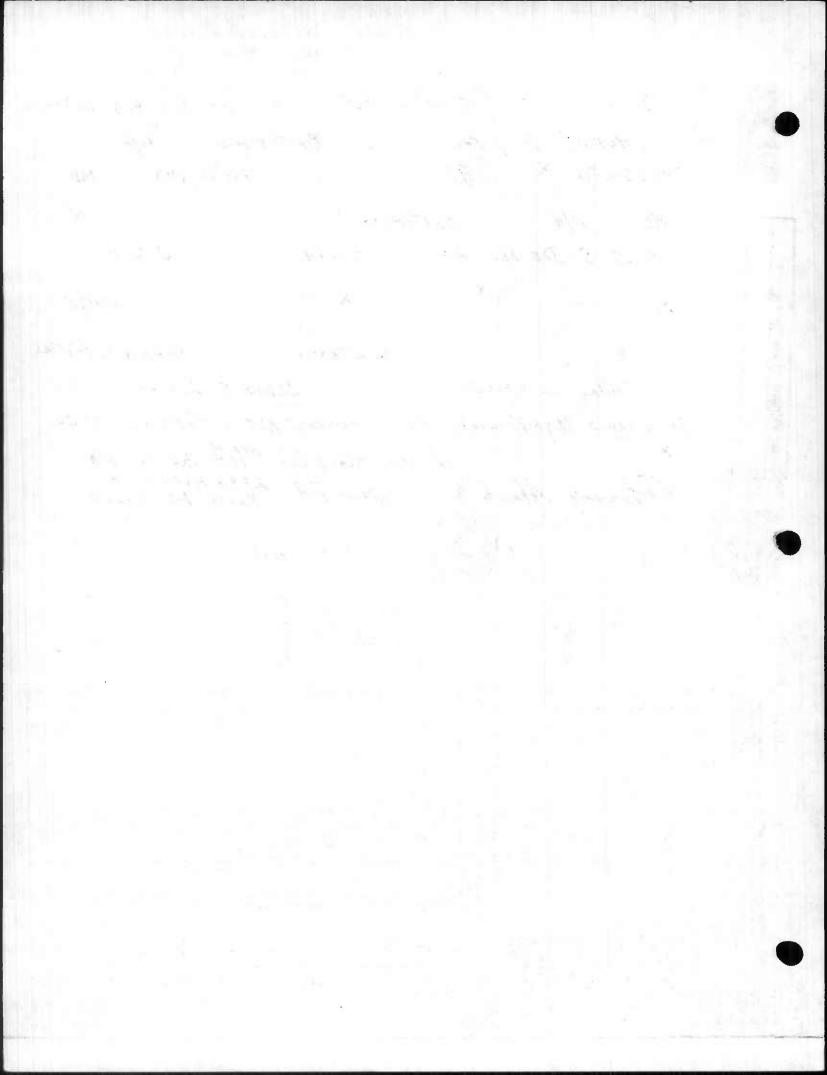
30. Name and address of person who complated cause of deeth (Itam 23a) (Type, Print)

31. Data filad (Month, Day, Year) APR 2 2 1

32 Registrar's Signatura

Registrar

State



Phy /N Ex

Fund Dire

parmit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Nem 27 is marked other than "natural", or Nems 23s or 28e-1 show

Physic /Med

Baltimore, Maryland 21215-0020

| MS: #23 PART I, 27 PE | State of M | laryland | / Dep | partment of | f Health a | | | ne 99 | 13 | 254 |
|---|---|------------------------|--------------------|---------------------------------------|-----------------|-----------------------|----------------------------------|-----------------|-----------------------------|-----------------------------------|
| 1. Decedent's Nama (First, Middla, L. | | | 00 | Jitinoato C | n Doutin | 2 | Reg. 2. Data of Death | | | Time of Death |
| JADA A | A. KEENE | | | | | A | Month pril 20. | 1999 | rear | 0:35 A. |
| 4a Facility Nama (If not institution, gi | va street and number |) | | | 4b. City, To | | ition of Death | 4c. County of | | |
| Harbor Hospital | Center | | | | Balt | imore | | N/A | | |
| | Sex 7. A 1 M 2 F | ga (In yrs. la: N/A | st birthda Yrs. | Months Da | | Min. | Data of Birth (Month, Day, Ye | | 9. Birthplaca (Country) | Stata or Foreign |
| Usual Rasidence of Dacedant 10a. Stata 10b. County | | 10c. City, | Tour or | Location | | | | | 10d to | side City Limits |
| MARYLAND N/A | | Toc. City, | | TIMORE | | | | | | Yes 2 No |
| | | | DAL | | | | 10- | ON | | - |
| 10e. Street and Number 2404 WILGREY C | COURT | | | 10f. Zip Cod | 21230 | | 109. | U.S.A. | | |
| 11. Merital Status | 12. Was Decedan | Ever in U,S | . 13 | 8. Was Decedent | of Hispanic Ori | gin? (Speci | fy Yes or No- can, atc.) | | American In- White, etc. | dian, |
| 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 X If Yes, Giva Yeer or Datas: | No | | 1 □ Yas 2/0 | | | | 100 | 100 | MERICAN |
| 15. Decedent's E (Specify only highast gr | Education rada complated) | | 16a. Dec | cedent's Usual Oc | cupation | t of working | 161 | b. Kind of Busi | ness/Industry | |
| Elementary/Secondary (0-12) | Collega (1-4or | 5+) | lifa | va kind of work do . DO NOT use re | tired) | | | | | |
| N/A | n/a | | | NONE | | | | NONI | | |
| 17. Fether's Nama (First, Middla, Las KEVIN KEENE | 1) | | | | | ar's Nama (HY SM) | First, Middle, Mai | den Sumama, | , | |
| 40. 14 | | | 405 11. | N/- A dd (Os- | 4-12- | | | She as Town C | tota Tin Cod | -1 |
| 19a. tnformant's Name/Ralationship CATHY SMITH | MOTHER | | | illing Address (Str 4 WILGRE | | | ALTO, MD | | | " |
| 20a. Mathod of Disposition | | | ce of Dis | position (Nama o | f | | | c. Location - C | ity or Town, S | iteta |
| Na Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Special Control of Contr | | MT. | | ramatory or other N CEMETE | | APRII | | 99 Balt | | |
| 21. Signature of Funeral Service Lice | 3 | | 200 | 22. Nama end Ad CALVIN E | . SCRU | GGS FU | | | | |
| 23a Part1 Enter the disease or cor | nolications that cause | Shakash | Do not a | 1412 F. | PRESTO! | STRI | TET BAL | TO, MD. | 212 | oximete |
| 23a. Part1. Entar tha disaase, or conshock, or haart failura. List only Immediata Causa (Final disease or condition rasulting in death) | y ona causa on aach | 77 | | ANT DEATH S | | | | | fnte | vat Between et and Death |
| | | Due to (or | as a cons | sequence of): | | | | | | |
| | b | | | | | | | | 1 | |
| Sequentially list conditions, if any, leeding to immediata | | Dua to (or a | as a cons | equenca of): | | | | | | |
| cause. Enter Underlying Cause (Disease or trijury that initiated evants | C | Due to /- | | anuance of | | | | | - | |
| rasulting in death) Last | | Due to (or a | as e cons | equence of): | | | | | | |
| | d | | | | | | | | | |
| Pert II. Other significant conditions | contributing to death | hut not recule | ling la the | undarbina carres | niven in De- | | 23h Did toha | oco use cont | ribute to the | cause of death |
| rotti. Other agrinicant conditions | contributing to death | DOL HOL 1850K | ang ar are | unoanying cause | I given in reit | | | | 3 Probably | |
| | | | | | | | 24a. Was an a | | 24b. Wara a | utopsy findings |
| | | | | | | | performe | d7 | comple of deeth | e prior to lion of cause 1? |
| | | | | | | | performe | d7 2□No | of deeth | ion of cause |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunal-transit completely filled in by the funeral director, page 2 should be deteched for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To

1 Yas 2□ No 27. Menner of Death 1 🖾 Natural

4 Homicida 29a. Certifiar (Check only one)

5 Pending investigation 2 Accident 3 Suicide

6 Could not be datarmined

28a. Data of tnjury (Month, Day Year) 28a. Ptace of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signatura and titla of cartifian

30. Nama and address of person who

plated causa of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

O.C.M.E.

April 21, 1999

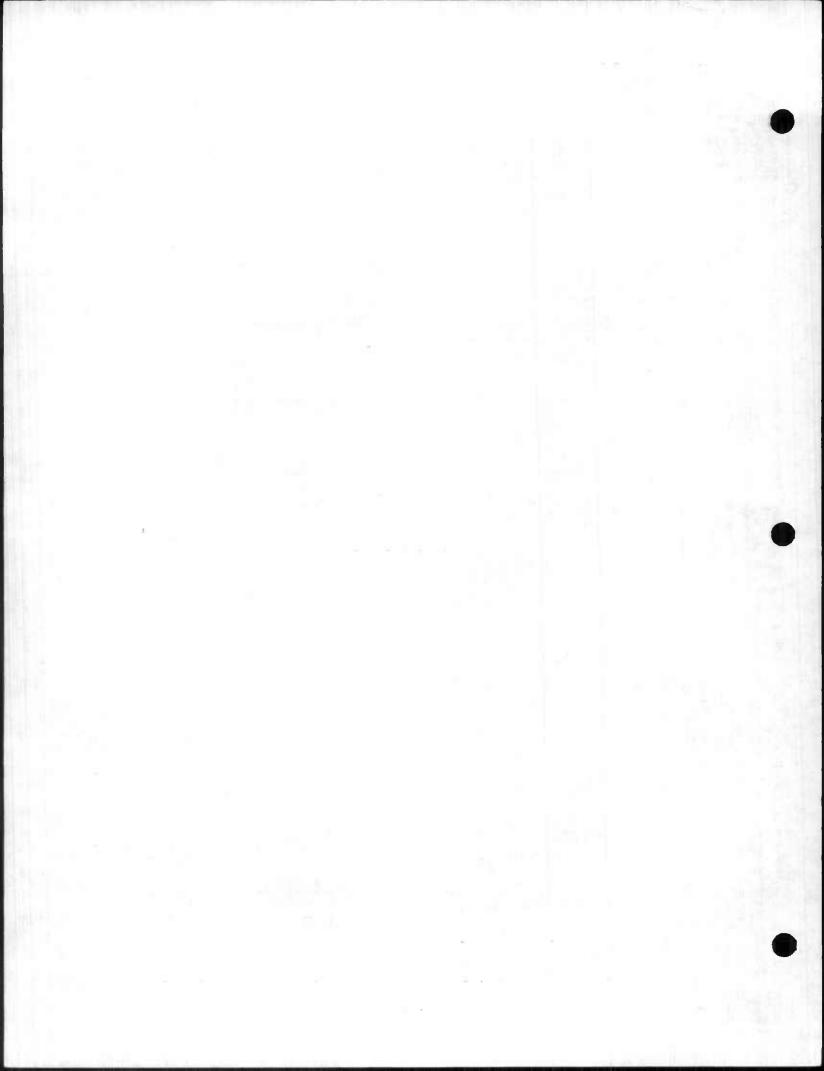
Dennis

hute, ma 31. Data filed (Month, Day, Year) APR 2 2 1999

32 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar



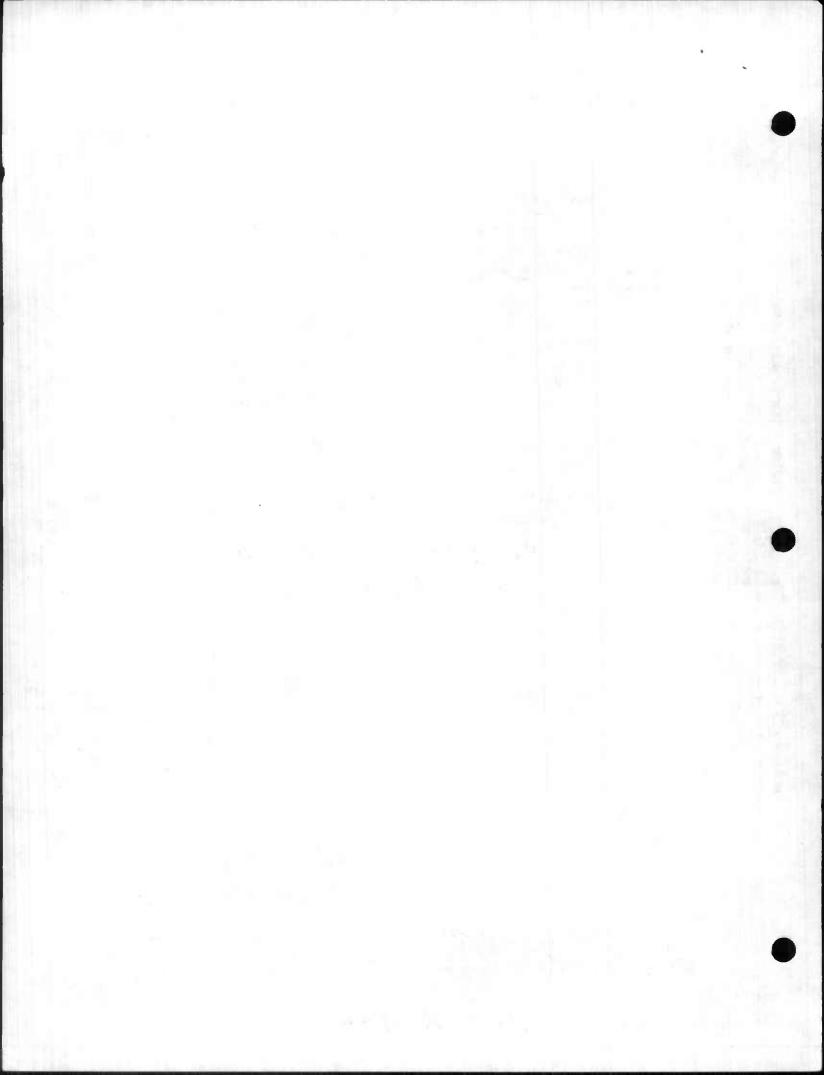
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 26 per M.D G-770 4/22/99 reb Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mattie Tamzie Knudsen 1999 9:15 P.M. 6 April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 22, 1905 Grant Co. AR **Funeral** Days 10 M 20 F Months Hours 431 30 3213 94 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location iral", or items 23a or 28a-f ahow Examinar must be notified at 10d. Inside City Limits Anne Arundel Crofton 1 ☐ Yes 🌠 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 United States 2131 Davidsonville Rd. ages 1 and 2 should be filled within 72 hours after deeth mid 6 Heeth and Mental Hyglens.

If then 27 is marked other than "natural", or have not other traumath. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3.☐{Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paper Industry General Labor Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah F. Rinehart Minnie Ola Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Heaton Daughter-In-Law 1625 Rossback Rd. Davidsonville Maryland 21035 Pages 1 ment of He 20a. Method of Disposition

1 Durial 2 Cremation 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department 4 ☐ Donation 5 ☐ Other (Specify) Orion Cemetery April 10, 1999 Redfield, AR 21. Signature of Funeral Service Licen 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. or Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Appril 20715 Approximate Interval Between Onset and Death Physician /Medical mediate Cause (Final ease or conditi ulting in death Examiner Examine Due to (or as a consequence of) The law requires that the death certificate be exe physician s the burta P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? E 20 No 1 Yes 3 Probably 4 Unknown ped ad I Records. à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate of Vital å 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To 1 Yes 200 1 Inpatient 2 ER/Outpatient 3 DOA # mor of D 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Atter Division Hospital or Attending Natural 5 ☐ Pending death. 2 Accident 1 | Yes 2 | No after death 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Combined Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

20 Index of Examiner Con the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical ompletely To the 29b. Signature and title of Portific 29c. License numbe 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | A Davidson Niver (Circl Mindson | | marylan | | tificate of | Death | Re | g. No. | 13 | 256 |
|--|---------------------|---|---|--|--------------------------------|--|--|--|----------------------------------|-----------------------------|--|
| Physic /Medi | | Decedant's Nama (First, Middle, L | Randa | a11 | Louis | Link | ous | 2. Dete of Death Month AF'RIL | Day 18, 1 | Year 999 | 3. Time of Death 10:29AM |
| Exami | | 4a. Fecility Nama (If not institution, g Saint Joseph | | | e r | | 4b. City, Town, or Lo | | 4c. County | ot Death | nore |
| Funeral Director | | 5. Social Security Number 6. 218-08-9722 | Sax 7. ≱□ M 2□ F | Age (In yrs. i. | ast <i>birthd</i> ey) Yrs. | If Undar 1 Yeer Months Days | | 8. Data of Birth (Month, Day, Sept. 18 | Year) 8,1958 | | aca (Steta or Foraign ry) Jinia |
| ylend . | | Usual Rasidanca of Dacedant 10a. Stata 10b. County | | 10c. City | , Town or Lo | cation | | | | 10 | d. Insida City Limits |
| ath with the Marylen 23s or 28s-f show | ector | | ltimore | | | | Dung | dalk | | | 1 ☐ Yas 2 ☐ No |
| with it | Dir | 10e. Street end Number 2000 Paulette F | tar bee | #2 | | 10f. Zip Coda | 21222 | 10 | g. Citizan of V United | | • |
| Herne Dec.m | by Funeral Director | 11. Meritel Stetus 1 Navar Married 2 Married 3 Widowad 4 Divorced | 12. Wes Decede Armed Force 1 Yas 2 If Yas, Give Yaar or Data | ent Ever In U, as? PNo | | Was Dacedant of It It Yes, specify Cub | Hispanic Origin? (Spean, Maxican, Puarto | ecify Yes or No- Rican, atc.) | 14. Rac | e - Amarica ck, Whita, e | in Indian, itc. |
| 15-00: | ted | 15. Decadent's E (Specify only highest g | ducation | | 16a. Deced | lent's Usual Occup | pation | /02 | 6b. Kind ot Bu | | White ustry |
| 21215-0020 d within 72 hours ef giena. w then "natural", or if the Wedical Evert | Completed | Elementery/Secondery (0-12) | College (1-4 | or 5+) | | | during most of work d) | | | | |
| Waryland 212 12 should be filed within and Mental Hygiena. 1 is merked other than | Be Co | 12 Year 17. Father's Nema (First, Middle, Las | t) | | C | onstruct: | ion Worker | | aiden Sumam | | ruction |
| Maryland nd 2 should be file lith and Mental Hy 77 is merked othe r traumatic event, | To B | Fred Linkous | | | | | Pauli | ne Coopei | c | | |
| Maryia d 2 should th and Men 7 is marks traumatic | ľ | 19a. Informant's Name/Raietionship | | | | | and Number or Run | | | | |
| e, N 1 and Heelth Pm 27 ther ti | | Sandra Smith/Si 20a. Mathod of Disposition | ster | 20h Pi | | | Ave. Apt | | ltimore Oc. Location - | | 21224 |
| Pages Bent of Ht: If the | | 1 ☑ Burial 2 ☐ Cremetion 3 i | | 1(81 | | sition (Nama of natory or other ple | esus Cem. | | | , | |
| Baltimore, M. pemit. Pages 1 and 2 Department of Heelth a important: If item 27 is any Injury or other tra once. | | 21. Signature of Funeral Service Lice | | , 50 | 22 | . Nama and Addra | | | | | aryland |
| m 89F28 | | Octube | Con | una | | 7922 Wis | e Ave. Di | undalk. N | Marvlar | | 1222 |
| | | 23a. Part1. Enter tha disaase, or col shock, or haert tailura. List only | iplications that cau ona causa on aac | sed the death h lina. | Do not ent | ar tha moda of dyi | ng, such as cardiac | or respiretory arra- | st, | | Approximate Interval Between Onsat and Death |
| Physician /Medical | | Immediata Causa (Final disaasa or condition | RESPIR | RATORY | / FAI | LURE | | | | | DAYS |
| Examiner | L | rasulting in death) | a | Dua to (or | as a conseq | uence of): | | | | | |
| pet led | nine | | b. ADULT- | | | 1 | RESS SY | NDROME | | I | DAYS |
| 68760, ficate be executed physician end st the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated events | c. PNEUMO | DNIA | as a conseq | | | | | I | DAYS |
| | 0 | rasulting in deeth) Last | a. HUMAN | | as a conseq | uence ot): ICIENCY | VIRUS | | | , | YEARS |
| O. B. | by Physician/M | Pert il. Other algnificant conditions | contributing to deat | h but not rasu | iting In the u | ndarlylng causa gi | van in Pert I. | 23b. Did tob | acco use cor | ntribute to | the cause of death? |
| P.O. hat the ded by the detached | Phy | PANCYTOPENIA | | | | | | 1 □ Ye | • 2□ No | 3 Probe | ably 4 Unknow |
| Division of Vital Records, P.O. Box (or Attending Physician: The law requires that the deeth certif- effer death. Director: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use ex | Completed by | ALCOHOLISM | | | | | | 24a. Was an perform | autopsy ed? | 24b. War aval com | ra autopsy findings llable prior to apletion of cause eath? |
| I Re law ate has page 2 | Som | | | | | | | 1 ☐ Yas | 2 No | | Yes 20 No |
| f Vital Rivelen: The Is certificate hadirector, page | Be | 25. Was casa ratarrad to medical axaminar? | 11:2:1 | | | | | h (Check only ona |) | | |
| of Vita Physician: this certific | . To | 1 ☐ Yes 2 No 27. Mennar of Death | Hospital: 1 Inp | | ER/Outpatier 28b. Tima of | I SLI DOA | | me 5 Resider | | |) |
| Sion tending leath. tor: After the fune | Certification: | 1 Anaturel 5 Pending 2 Accident invastigation 3 Sulcide 6 Could not | 200 | | Injury | M 1□ | rk? Yas 2 No | | | | |
| Divi | Certif | 4 Homicida determinad | 28a. Place of | Injury - At hor atc. (Specify | ma, farm, str | aet, factory, office | | 28f. Location (Str. City or Town, | aat and Numb Steta) | er or Rural | Houta Number, |
| Division of To the Hospital or Attending Previous effer death. To the Funeral Director. After the completely filled in by the funeral | Medical | 29a. Cartifiar (Check only one) Certifying P | hysician: To tha be miner: On tha basis and menner | st of my know s ot examinati stated. | riedga, daath on and/or inv | occurred at the time time occurred at the time occu | ma, data and place, opinion, daath occurr | and dua to tha car ed at tha tima, da | usa(s) and ma ta and piace, i | nner as ste and dua to | itad. the cause(s) |
| To the to the total | M | 29b. Signatura and title of certifiar | L.L. | AR. | can | 29c. Licans D318 | | 29 | d. Data signed | d (Month, D | lay, Year) |
| Who | / | 30. Nama and address of person who | complated cause of | of deeth (Item | 23a) (Type, | Print) | | , | | | V |
| 0 | | RICHARD L. LIN 31. Data tilad (Month, Day, Year) | THICUM, I | | | OSLER D | RIVE, TO | OWSON, M | ARYLA | ND 2: | 1204 |
| Str Regist | 400 | . Data mad (Moritin, Day, 1981) | 32. Hegi | strar's Signat | | 4. Spo | e Kal | | | | |
| DHMH 15 Pay 5/9 | - | APR 27 | 1999 | 0 700 | 10 | · jugo | | | | | |

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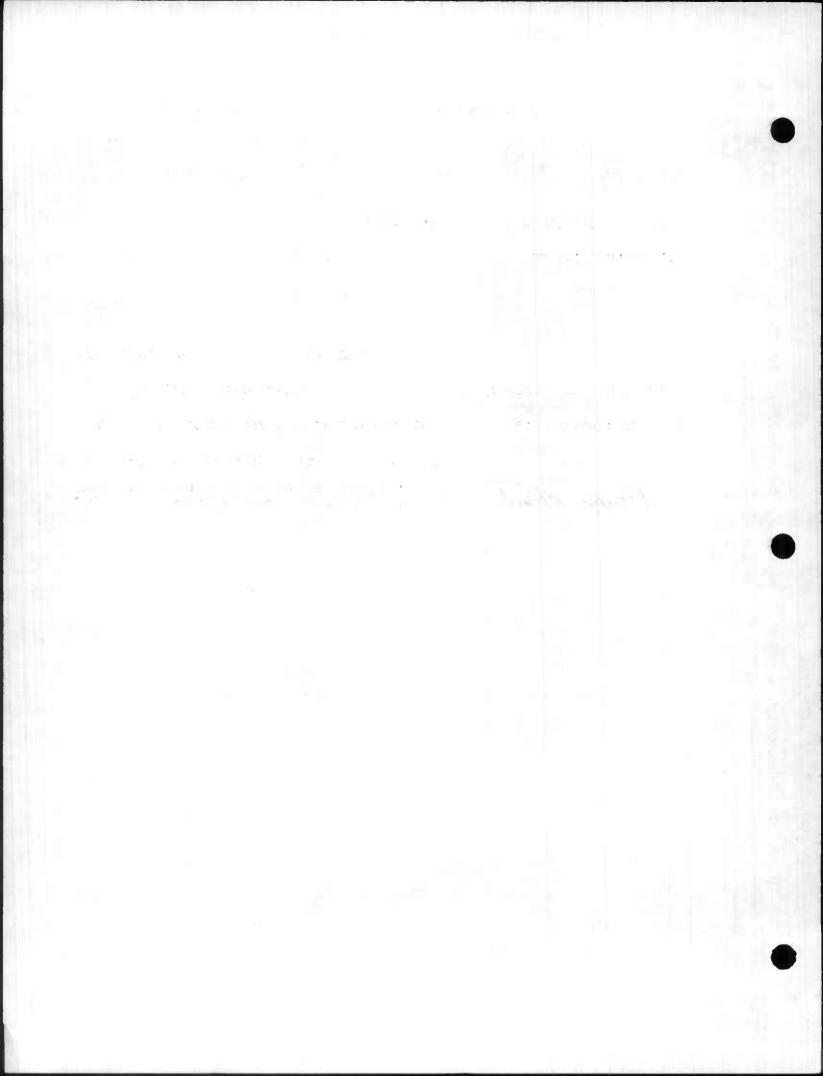
State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death

| Physician | 4 Decedes | | | | | | | | | | | Reg. I | | | 1 | |
|---|--|--|--|---|---|--|---|----------------|--|------------------------|--|--|---|--|--|--|
| /Medical | | nt's Nama (First, Mid FREDERIC | | LIME | PERT, J | r. | | | | | A P | थं। | Day | Year 999 | | of Deal |
| Examiner | 4a Facility | Name (If not instituti | | eet end num | | | | 4 | | | ocation of | | tc. Count | y of Death | | |
| uneral rector | | 3-8034 | 6. Sax 1380 M | 2□ F | 7. Age (In yrs. 81 | Vre | ff Undar Months | 1 Yaar Days | If Unda Hours | Min. | 1000 | of Birth h, Dey, Yea 2 191 | | 9. Birth | olaca (Stet otry) | |
| | | dance of Decedant | | | | | | | | | | | | | | |
| T thow | 10a. Stata | 10b. Count | ty | | 10c. Cit | y, Town or Lo | cation | | | | | | | | Od. Inside | |
| 23a or 28a-f show at be notified at al Director | MD | | TIMOR | E | C | CATONSV | | | | | | 1.0 | | | 1 🗆 Y | 15 2L |
| Oir Di | 10e. Street | and Number | | | | | 10f. Zip | | | | | 10g. (| | What Cou | ntry? | |
| resil | 11. Marital | LENWOOD A | | Was Decer | dent Ever in U | S 13 1 | Was Dece | | L228 | iolo? (Sr | ecify Yas | or No- | US 14 Ba | | can Indian, | |
| il', or items 23a or 28a-f a Exercises must be notified by Funeral Director | | ver Marriad 2⊡(Ma dowed 4 ☐ Divorce | arried | Armed Ford 12 Yes 2 If Yas, Giva Year or Da | cas? 2 □ No | | Was Deced f Yas, spec 1 ☐ Yes | | | | Rican, ald | ā.) | | ck, Whita, | etc. | |
| ner than "natural", rt, the Medical Exi Completed by | | 15. Deceda (Specify only high | ant's Educati | ion om <i>pleted)</i> | | 16a. Dece | kind of wo | rk done | durina mo | st of work | ding | 16b. | Kind of B | Jusiness/Ir | | |
| - 40 | Elementa | ary/Secondery (0-12) |) | Cotlege (1- | 4or 5+) | lite. I | ACCOL | | | | | DG | :O DX | IL R | מאר | |
| 2 4 0 | 17. Father's | Name (First, Middle | e, Last) | 3 | | | ACCOL | INTAL | | ar's Nam | a (First, M | iddle, Maid | | | JAU | |
| å å | | DERICK H | | MPERT. | SR. | | | | ELS | | MARII | | CHTE | | | |
| 7 is marked of traumatic every To Be | | ant's Name/Ralation | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 19b. Mailir | ng Addrass | s (Street | | | | lumber, Cit | | | Code) | |
| 27 rt | R. MA | RIE LIMPE | RT, W | IFE | | 27 GI | ENWO | DD AT | ENUF | , CA | TONS | /ILLE | MD | 21228 | 3 | |
| | 20a. Matho | d of Disposition | | | | Place of Dispo | sition (Nei | me of | | | Data | | | | own, Stata | |
| nt: if | | rial 2 ☐ Cremation mation 5 ☐ Othar (| | noval from S | lata | . JOHN | | | | 4 | -19-9 | 9 ELI | LICOT | T CI | CY. M | D |
| Important: If I any injury or once. | 21, Signatu | re of Funeral Service | e Licensee | _ | | 22 | . Nama ar | nd Addra | ss of Facil | ity | | | | | | |
| E . G |) | Willer | 14 | ali. | | | | | | | | TUNERA ALTIMO | | | | |
| | 23a. Part1 | . Enter tha disaasa, or haart failure. Lis | or complicat | tions that ca | used tha daat | | | | | | | | , unit | MD 2. | Approxin | nete |
| sician | SHOCK | , or naan ranure. Lis | si only ona c | causa on ea | ion lina. | | | | | | | | | 1 | Intervel E Onsat an | d De |
| edical | Immediala disaasa or | Causa (Final | | SE | PSIS | | | | | | | | | | 2 ws | 100 |
| miner | resulting in | daath) | a | | Due to (c | | | | | | - | | | | | |
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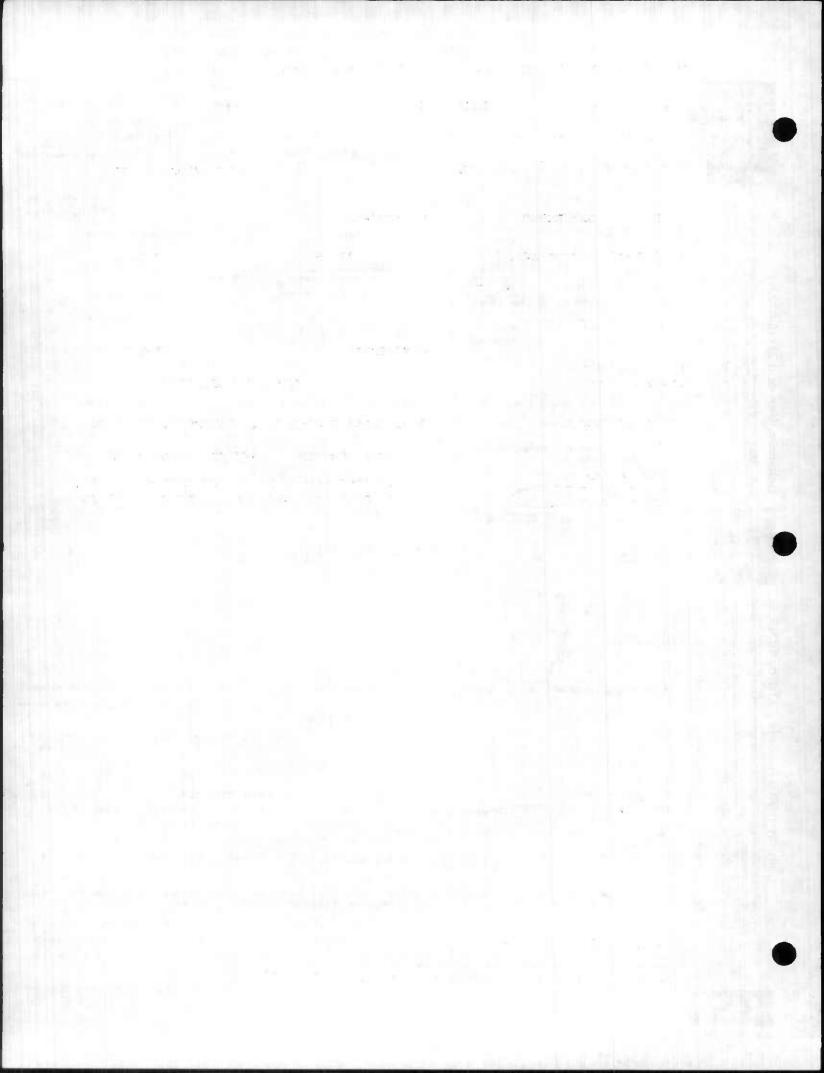
THE DE PUCIL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 Item: 1 per M.D G-770 4/22/99 reb Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death Month A PRIL **Physician** 1499 11:01 AM LEYINE, WILLIE WILLIE LEVINE 10 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Bayview Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 12 M 2 □ F 5. Social Security Number 8. Dete of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** Months Days Hours Min. 247-20-6865 72 Yrs. 11/24/1926 SC Director Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be northled at 1 Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4908 FRONANK FORD AVE. 21206 U.S.A. 14. Race - American Indien, 2 should be filed within 72 hours after death is and Mental Hygiene.
Is marked other than "natural", or items 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, etc 1 □ Never Merried 2 □ Married Specify: BLACK Baltimore, Maryland 21215-0020 1 Yes 2K No Specify þ 3X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) JANITORIAL SANTEE 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fethar's Nama (First, Middla, Last) ALFRED LEVINE ROSATTA WASHINGTON 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important. If then 27 is n any injury or other traun CLAIR LEVINE/SON 4908 FRONANK FORD AVE. BALTIMORE, MD 21206 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 XBurial 2 Cramation 3 Ramoval from Stete WESLEY A.M.E. CHURCH 4/24/99 SHULERVILLE, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furying Service Licensee 22. Name and Address of Facility
STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiec or respiretory errest, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finel severe eardiomy orathy 20 years diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner the attending physician and thed for use as the bunal-transit certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents Due to (or es e consequença of): Box 68760, Physician/Medicai Due to (or as a consaquance of): resulting in deeth) Last Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t d be detach 1 Yea 2 No 3 Probably 4 WUnknown þ Records, 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en autopsy performed? completion of cause of deeth? has 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 9 1 Tyes 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this 28d. Describe how Injury occurred 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Meturel death. 1 TYes 2 TNo after death Director: / 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 \ Homicide To the Hospital within 24 hours To the Funeral I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) and menner es stated. Medical 2 Medical Examiner: On the besis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of cartifiar Drawes (les 98039 April 20 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Johns Hopkins Baynew Medical Center A Klan, MD DIUNE 31. Dete filed (Month, Day, Year) APR 2 2 1999 32, Registrer's Signeture Registrar

2 Par



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JOHN LEYH 4b. City, Town, or Location of Death 1993 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Co of HOWARD Columbia

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) HOSPICE HOWARD If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 180 M 2□ F 213-09-5954 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21206 5922 PLAINFIELD USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 72 hours efter 1 ☐ Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WITITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelth and Mentel Hygiene. Important: if Item 27 te marked other than frent fillury or other treumatic event. Insulant Elementary/Secondary (0-12) College (1-4or 5+) HOME CHAFFEUR FUNERAL 6 NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be WILLIAM LEYH 5 MARGARET H EROLD 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) AU. BAItO NO 21206 PLAINFIELD HELEN LEYH 922 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 199 BALTIMORE REM. CITTO 21. Signature of Funerel Service Licensee 22. Name end Address of Facility ILER FYREKAL (-lame, Balto Ned 21234 23a. Pertf. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician the the buriel Box 68760 Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. entra - No.0.5 1 Yes No 3 Probably 4 Unknown Š 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed hes 27 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred il or Attending P i efter death. I Director: After After 1 Maturat 5 Pending 1 | Yes 2 | No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Mospital of 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner steted. 29a. Certifier edical (Check only one) To the I within 2

State Registrar

KUCODRY BE 31. Date filed (Month, Day, Year) APR 2 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type,

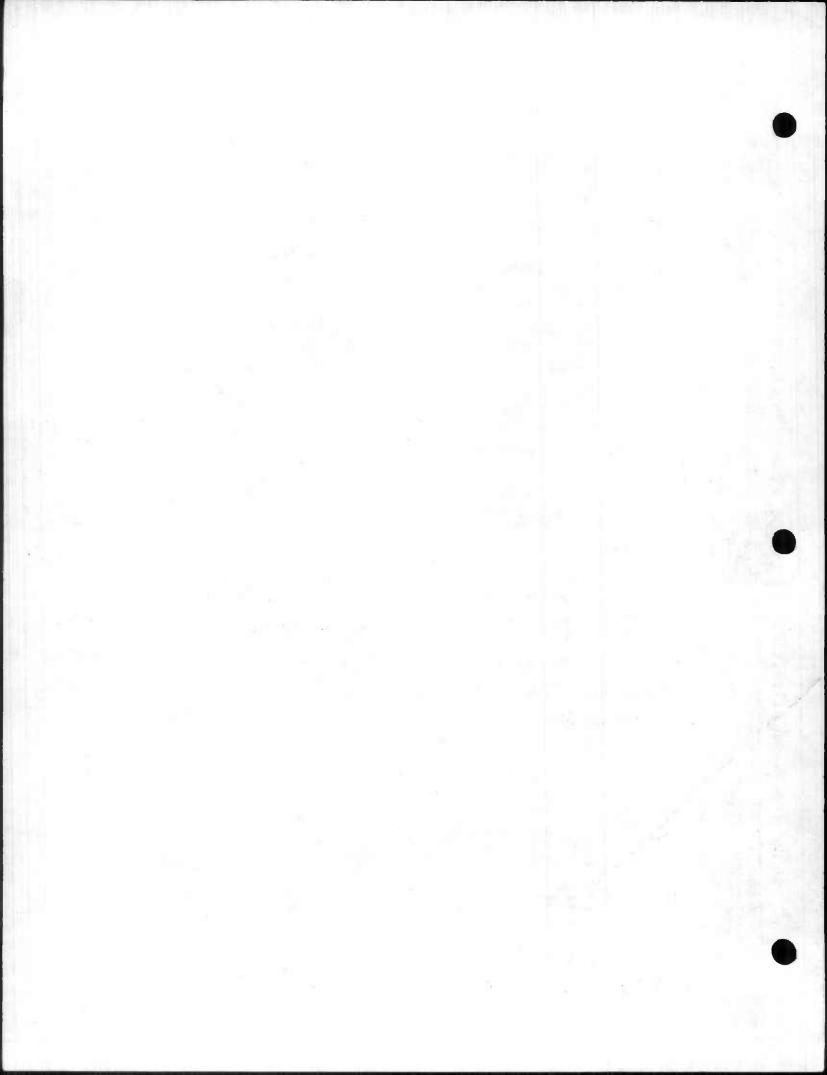
29b. Signature and title of certifier

9501000 32. Registrar's Signeture

DHMH 16 Rev 6/95

29d. Dete signed (Month, Day, Year)

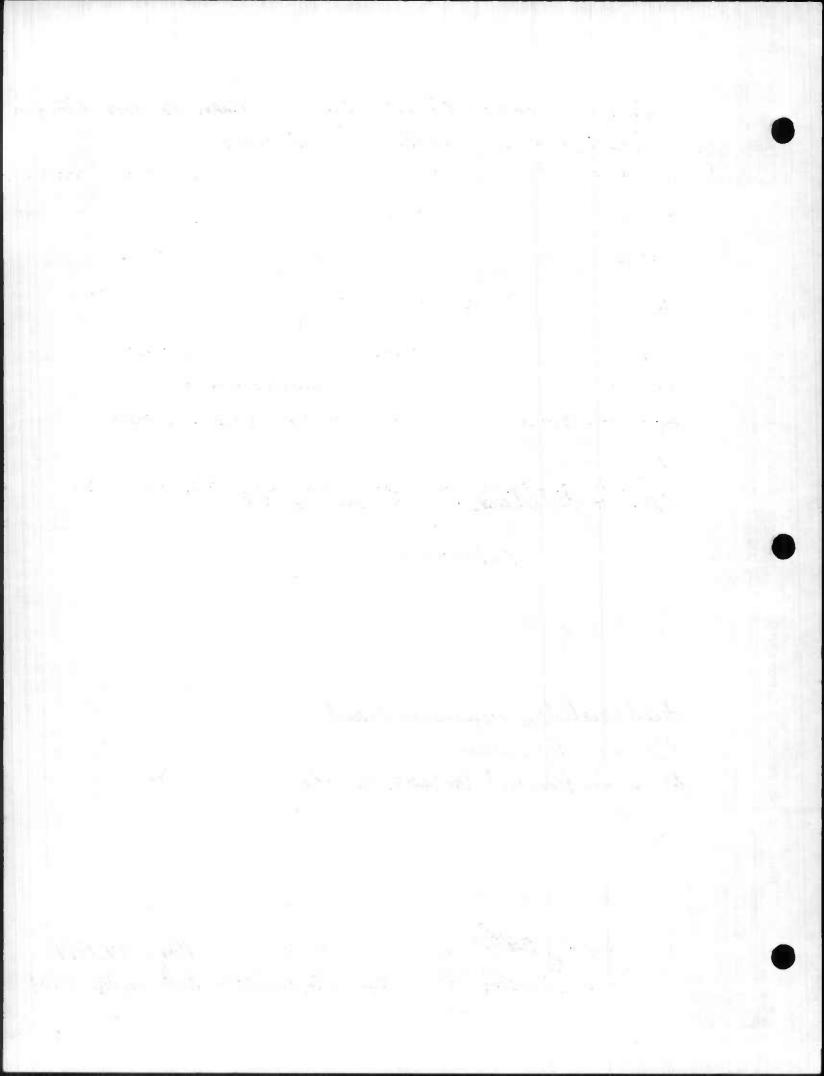
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State of Maryland / Department of Health and Mental Hygiene 0 13260

| sician | 1. | Decedent's Nem | e (First, Middle, | , Last) | 1 | / | MOORE | 5 | | 2. | Dete of Dea | Dey | Year | 3. Time of Deeth | |
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| miner | 40 | Tabak | - Hook | KINS C | 1 | tisel | ESTEL 2 | 505 Haprin | Ba | 14. | RE | 40. County | OI Deelli | | |
| eral | 5. 3 | Sociel Security N | lumber | 6. Sex | 7. Ag | e (In yrs. | last birthday) | If Under 1 Year | If Under 2 | | Dete of Birth (Month, Day | Veas | 9. Birthpla | ace (State or Foreig | n |
| tor | | 39-14-9 | | 1 X M 2 | F | 7 | 77 Yrs. | Months Deys | Hours | | | | | "Carolina | ı |
| 100 | - | uel Residence o a. State | 10b. County | | | 10c. Cit | ty, Town or Loc | ation | | | | | 10 | d. Inside City Limits | |
| by Funeral Director | M | aryland | | | | Bal | ltimore | | | | | | | 1 Yes 2 □ No | , |
| Director | 10 | e. Street end Nu | mber | | | | | 10f. Zip Code | | | | 10g. Citizen of \ | What Count | ry? | |
| | | 1213 Qu | antril V | Way | | | | 2120 | | | | U.S. | | | |
| Funeral | 11. | . Maritel Stetus | | 12. Wa | as Decedent I med Forces? | Ever in U | ,S. 13. W | les Decedent of I Yes, specify Cub | Hispenic Orig an, Mexican | gin? (Specify), Puerto Rica | Yes or No- an, etc.) | 14. Red Blee | ce - America ck, White, e | | |
| by F | | 1 ☐ Never Merr 3 ☑ Widowed | led 2 Merrie 4 Divorced | If Y | Yes 2 1 h Yes, Give er or Detes:] | | -46 | ☐ Yes 251 No | Specify: | | | Specify | y: wh | ite | |
| | | /6 | 15. Decedent's | s Education | | | 16e Decede | ent's Usuel Occup and of work done | pation | t of working | | 16b. Kind of B | usiness/Inde | ustry | |
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| \$500 | 21 | Signature of P | onald S | icansee | 2 | | 22. | Name end Addre | | | 655 W | . Balti | more | St. | |
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32. Registrer's Signeture

VIOLETA

31. Date filed (Month, Day, Year)
APR 2 2 1999

AUE; BALTIMORE, 21229

funeral To the Hospital within 24 hours a To the Funeral Completely filled

Mitchell

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 2:25 AM 1999 Ethel Garnette Mitchell /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Baltimore FRANKLIN enter Koseda Spital Central Age (In yrs. lest birthdey) Square MOS 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys 1 □ M 2 ₽ F **Director** 215-24-1452 May 26, 1918 West Virginia 80 Usuel Residence of Decedent 72 hours after death with the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 7 is marked other than "naturel", or items 23s or treamstic event, the Medical Examiner must be a 6905 Brentwood Avenue United States Funeral 21222 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Peges 1 and 2 should be filed within 1 nent of Health and Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Own Home 8 years Home maker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Kelly E. Wilson Myrtle Baldwin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Health a least tree tree Garnette L. Mitchell Daughter 6905 Brentwood Avenue Baltimore, Maryland 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete = 8 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 4/21/1999 Beckley, West Virginia 21. Signature of Funerel Servica Licenses 22. Name end Address of Fecility okning L. Gebes Duda-Ruck Funeral Home of Dundalk, Inc. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest,

Approxime shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical DAYS Examiner Examiner physician and s the buriel-transit that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Physician/Medicai Due to (or es a consequenca of) signed by the a 23b. Did tobacco use contribute to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en autopsy Completed ils certificate hes b I director, page 2 s 1 Yes 1 Yes 2 No 2 🗆 No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifics Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. License number 011033 30. Neme end eddress of of deeth (Item 23e) (Type, Print) Zabihollah LahiJi 9000 Franklin Square Drive Baltimore Maryland 21237 M.D. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Day **Physician** tarline 1999 10:53 AM April /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 5. Social Security Number Heal theare If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 200 F Months Days 79 Director 212-14-7493 01/05/1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Md Baltimore Catonsville Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1920 Lismore Lane 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc 1 Yes ZN No If Yes, Give Year or Dates: 1 Never Married 2K Married Saltimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary Church 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or Earl Victor Thomas Ada Schifler 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) H. Allen Mills/Husband 1920 Lismore Lane, Catonsville, Md21228 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removel from State 8 4/20/99 Boonsboro, Md. Boonsboro Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Servica Licenses Sterling-Ashton-Schwab Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final MYD CardiAL Inforction disease or condition resulting in death) Examiner Examiner Hurt 2 Day Block physician end s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed by Earline Mills 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2X) No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter deeth. Director: Af 1 Yes 2 No 2 Accident investigation 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide ò 24 hours e 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler edical (Check only one) To the Within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 590 Danul Fremstein, MA April 17, 1999 HOUSE Officer 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

900 Caton avenue Baltimore, Muryland

DHMH 16 Rev 6/95

State

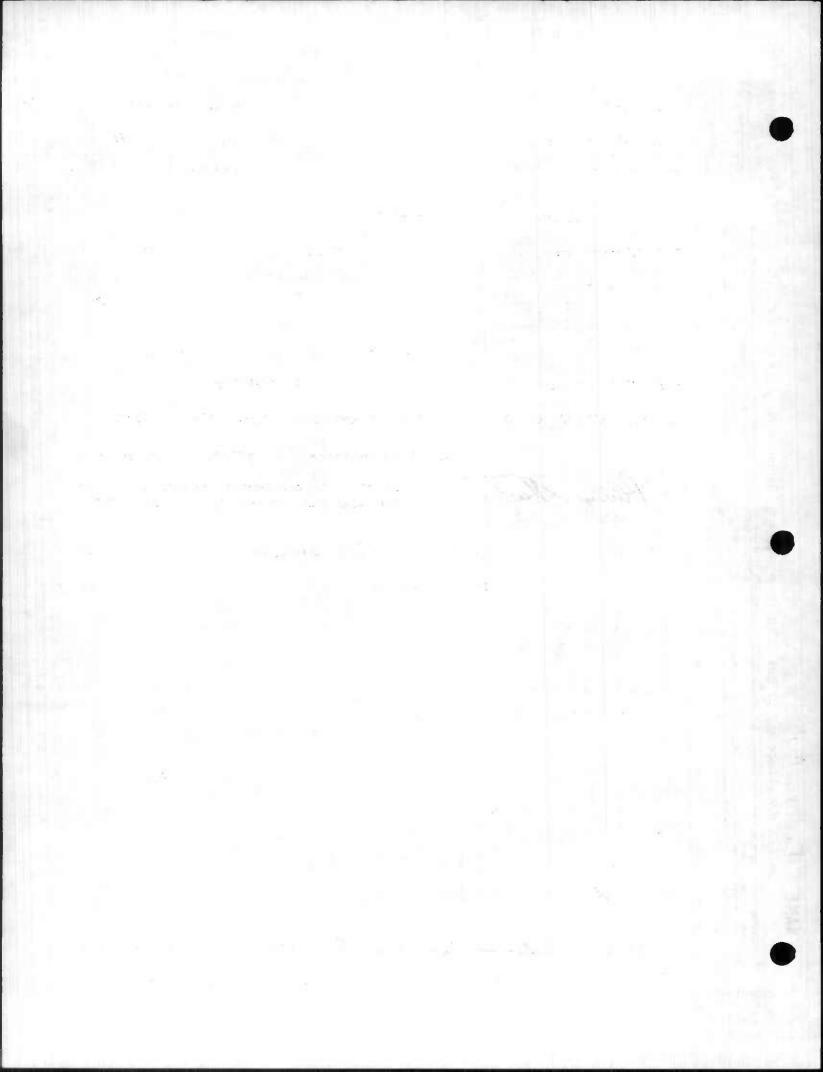
Registrar

Finstein, mo

32. Registrar's Signature

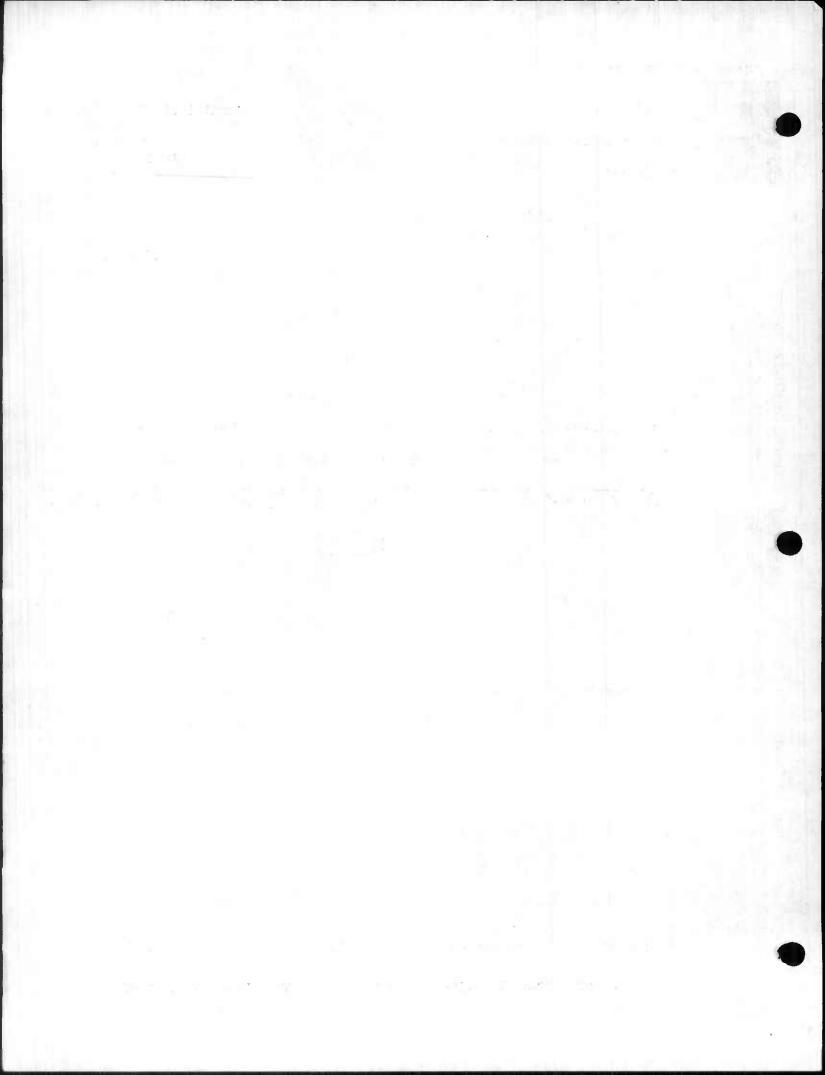
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31. Dete filed (Month, Day, Year)

APR 22 1999



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| | 3 | 1. Decedant's Name | a (First, Mido | da, Last) | | | | rtificate of | | 2. Deta of E | Reg. No. | | 3. Time of Death |
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| Examiner | r | 4e. Facility Name (II | | | | per) | | | 4b. City, Town, or | Location of Da | ath 4c. County | y of Death | |
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| neral ector | | 5. Social Sacurity No. 216-01-4 | 239 | | M 201F | . Aga (<i>in yr</i> s. | last birthday) Yrs. | Months Days | | Month, I | Birth 8-7-1910 7-1919 | 9. Birthplac Country Virg | |
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| be notified | 3 | 10e. Street and Nun | | | | | | 10f. Zip Coda | | | 10g. Citizan of | What Country | |
| Z3a or | | | undal | ν Δτ | 7.0 | | | 2122 | 2 | | U.S.A | | |
| free man | 5 | 11. Marital Status | andar | | 2. Was Decede | ent Ever in U | I.S. 13, \ | | | Specify Yes or M | | ce - Amarican | Indian. |
| b b | 2 | 1 Navar Marrie | | rried | Armad Force 1 ☐ Yas 2 If Yas, Give Yaar or Data | es? ⊠No | 1 | f Yas, specify Cut I □ Yas 2X No | Hispanic Origin? (: ban, Mexican, Pua Specify: | rto Rican, atc.) | | ck, Whita, atc White | |
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| meric event, the M | | 17. Fethar's Name (| First, Middla, | , Last) | | | | | 18. Mother's Na | ma (First, Midd | le, Maidan Suman | na) | |
| To atic | 2 | Clare | nce J | olle | tt | | | | Cora | Morri | S | | |
| E E . | | 19a. Informant's Na | me/Ralations | ship (Type | e, Print) | | 19b. Mailin | ig Address (Stree | t and Number or F | lu <i>ral Rou</i> te Num | ber, City or Town | Stata, Zip Co | oda) |
| important: if nem 27 is any injury or other trau once. | | Kathle | een P | aul/ | Daugh | ter | 11 | Dundall | k Ave., | Balto. | ,Md. 21 | 222 | |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23 part I,26 per M.D G-770 4/21/99 rebCertificate of Death 1. Decedent's Neme \First, Middle, LAt 2 Date of Deeth 3. Time of Deeth Mary Month 10, ourson 4e. Fecility Neme (If not Institution, we street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Rd. Junniper Baltimore Baltimore Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) If Under 1 Year 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) Months 1 M 20 F Days 54424 95 Yrs. Sept. 16, 1903 Pa. Usuat Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Baltimore Baltimore Md. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21218 3799 Junniper Rd. USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritet Stetus 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Dacedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Bustnass/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) 12 Registered Nurse Health 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Sumeme) William E.Selser Lillian Bosserman 19e. Informent's Neme/Retettonship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 3799 Junniper Rd., Baltimore, Md. 21218 Dr. Samuel Morrison 20b. Ptece of Disposition (Name of cametery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Smithsburg 1 ☐ Burlet 2 ☑ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematorium Wash.Co.,Md. 21. Signature of Furteral 22. Name end Address of Fecility Service Liceases Lininger-Fries Funeral Home N. Park Ave., Mercersburg, Pa. 17236 mms M 23a. Pert1. Enter the disease, or complications that causad the deeth. Do not entar the mode of dying, such es cerdiac or raspiratory errest, shock, or heer feilure. List only one ceusa on aach line. Approximete Intervet Between Onset end Deeth ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE Immediate Ceuse (Finet disease or condition resulting in deeth) Dua to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en eutopsy performed? 24b. Were autopsy findings eveitable prior to completion of cause of death? 1 Yes

Physician /Medical **Examiner**

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physician

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Be

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Certification:

Medical

this certificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director,

that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

10a State

Director

Funeral

by

Completed

Be 2

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinar must be notified at

the Maryland

72 hours after

permit. Peges 1 and 2 should be filed within Department of Haalth end Mental Hygiena. Important: If item 27 is marked other than any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

Sequentietly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting to deeth) Lest Physician/Medical ģ Completed

1 Yas 2 No 25. Wes cese raferred to medical 26. Plece of Deeth (Check only ona) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5XX Rasidance 6 Other (Specify) Yes 2□ No 27. Menner of Daeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Naturel Accident 5 Pending Investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Piece of injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the causa(s) and manner as stated. 29e. Cartifiar

29b. Signeture and the of certifier

31. Dete filed (Month, Dey, Year)

2 Medical Examiner: On the basis of axaminetion end/or trivestigation, in my opinion, death occurred at the time, date end piece, end due to the causa(s) end mennar stated. 29c. License number 29d. Date signed/(Month, Dey, Year)

30. Name end eddrass of person who completed of

S601 Loch Ravin

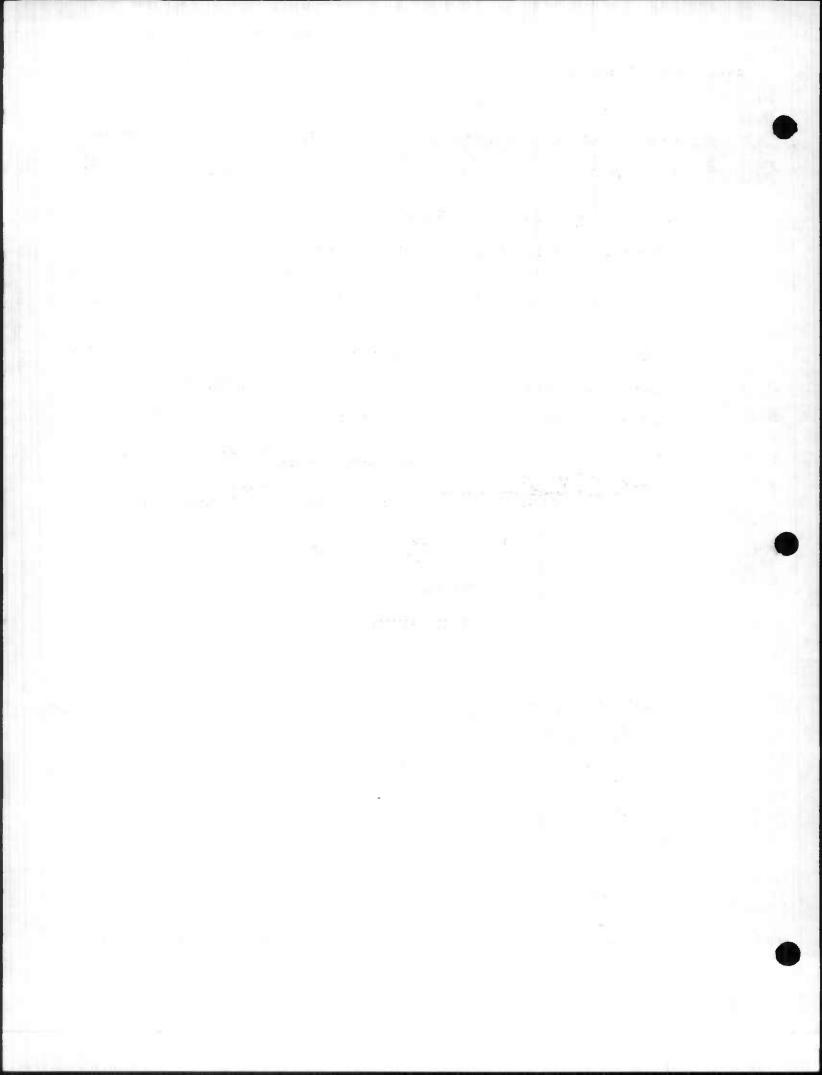
State Registrar



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| | Amend | ed#2 | 3ap1b-c perP | | | | Cer | tificate of | Death | 2. Date of D | Reg. No. | 7 1 | 3. Time of Death |
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| ı | Physic | | | | t B. Nie | ed | | | | Month | Day 5 1999 | Year | 3:30 PM |
| | /Medi Examiı | | 4a. Facility Name (If n | | | | | | 4b. City, Town, or | | th 4c. Cour | nty of Death | |
| 7 | | | Greater E | Baltimore | e Medica | I Cente | r | | Towson | | В | altimo | re |
| | Funerai Director | | 5. Social Security Nur 212-01-76 Usual Residence of D | 85 | ex 7 | . Age (In yrs. Ia 80 | st birthday) Yrs. | Months Days | | . (Month, D | irth Pay, Year) 1 1918 | 9. Birth Cou Ma | place (Stata or Foreig ntry) ryland |
| | aryland show | - | | 10b. County | | 10c. City, | Town or Loc | ation | | | | | 10d. Inside City Limit |
| | tha Maryle 28a-f sho | tor | MD | Baltin | ore | Tim | nonium | 1 | | | | | 1□ Yas 2 N |
| | th with | Funeral Director | 10e. Street and Numb | | alley Rd | ., Rm. | W006 | 10f. Zip Code 2109 | 3 | | 10g. Citizen o | f Whet Cou | ntry? |
| 21215-0020 | or No | Completed by Fune | 11. Marital Status 1 □ Never Married 3 ◯ Widowed 4 | | 12. Was Deced Armed Ford 1 Tas 2 If Yes, Give Year or Dat | No as: | 1 | ☐ Yes 2 XNo | | | | aca - Ameri lack, White, hity: Wh | etc. |
| 15-(| 72 nat | etec | (Specify | 5. Decedent's Ed only highest gra | lucation de completad) | | 16a. Deced (Give I | ent's Usual Occu | petion during most of wo | orking | 16b. Kind of | Business/In | dustry |
| 212 | d within piene. r than | dmc | Elementary/Second | lary (0-12) | College (1-4 | or 5+) | _ | retary | 9 <i>a)</i> | | Black | & De | cker |
| p | al Hygi other | Be C | 17. Father's Neme (Fi | irst, Middle, Last) | | a | 500 | ctury | 18. Mother's Na | me (First, Middle | | | |
| /lar | should be nd Mental marked o | To B | George | John Gi | lley | | | | Mary | Elizabe | th Baye | er | |
| , Maryland | 2 sh and Is m | | 19a. Informant's Nam Charles | | | | | | ok Rd., | | | | |
| Baltimore, | permit. Pagas 1 and Department of Health Important: If Itam 27 any Injury or other th | | 20a. Method of Dispos Burial 2 0 4 0 Donation 5 | Cremation 3 [| | ate cer | netery, crem | ition (Name of atory or other pla Valley N | nce) 4 Memorial | /8/99 Gardens | 20c. Location | | own, Stata |
| Balt | permit. Pagas Department of I Important: If its any Injury or of | | 21. Signature of Euro | ex | igle | | 22. Le | Name and Addr | ess of Facility uneral H | lome | | AD 21 | 003 |
| | - | | 23a. Part 1. Enter the shock, or heart f | | 1.44 | used the death. | Do not enta | r the mode of dy | donia Rd ing, such as cardia | ac or respiratory | errest, | ND 21 | Approximete |
| ı | Physician | | ondon, or mount | andro. Electority | one cause on ear | | | | | | | 1 | Interval Between Onsat and Death |
| 1 | /Medical Examiner | | Immediate Cause (Fir disease or condition resulting in deeth) | nal | θ | 1 | 12/2 | ~/~ | psilvis | | | | |
| | | - | roouting in dootin) | | | Due to (or a | as a consequ | ience of): | | | | 1 | |
| | uted J Insit | ulm u | | | b | CIRRHOSI | - | * | | | | i i | |
| Ć, | axecu in and ial-tra | Exa | Sequentially list cond if any, leeding to imm cause. Enter Underly Cause (Disease or inj | itions, ediate | | | es a consequ | | | | | | |
| 68760, | ificata be axecuted g physician and as tha bunal-transit | edical Examiner | thet initiated events | | c | CHRONIC Due to (or a | nEPAILI is a consequ | | | | | | |
| | E 0 6 | 100 | resulting in death) Las | | d | | | , | | | | <u> </u> | |
| Box | The law requires that the death certata has been signed by the attending page 2 should be detached for use | Physician/N | | | | | | | | T | | | |
| P.O. | t the de | hysl | Part II. Other significe | ont conditions of | ontributing to deal | th but not result | | darlying cause g | iven in Part I. | | | | o the cause of death bably 4 Onknow |
| | s that ned t | by P | | 6 85 fe | | 1-1- | | | | . 'L | Yes 2□ No | 3 P10 | Dably 4 Onknow |
| Records, | w requires that been signed to should be deta | | Kr | 0 85/6 | 5 | • | | | | 24a. We | s en eutopsy formed? | 24b. W | ere autopsy findings |
| ecc | a law re has bev ga 2 sho | Completed | 11 | 1.166 | | | 106/2 | | | pon | ionnea : | CC | ompletion of cause death? |
| E E | | Com | 114 | 0-42112 | | | 110/3 | - | | 1 🗆 | Yes 2 No | 11 | □Yes 2☑No |
| /ita | iclan: The | Be | 25. Wes case referred examiner? | to medical | | | | | | eth (Check only | one) | | |
| of Vital | | 2 | 1 ☐ Yes 2 No |) | Hospital: | | R/Outpatient | 3LI DOA | | Home 5 ☐ Res | | | (y) |
| L | Ilng F | on | | 5 Pending | | Dey Year) 2 | 8b. Time of Injury | 28c. Inju Wo M 1 | iryat ork?]Yes 2 □ No | 28d. Describe | how injury occ | urred | |
| Division | deatl deatl ctor: y tha | fical | | investigation | | f Injury - At hom | e farm stre | et, factory, offica | | 28f. Location | (Street end Nur | nber or Run | al Route Number, |
| Ö | after Dire d in b | ert | 4 Homicide | determined | building | , etc. (Specify) | 10, 14,111, 01.0 | ot, ractory, office | | | own, State) | | |
| | To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Attar th completely filled in by the funeral | edical Certification: | 29a. Cartifiar | Certifying Ph | ysician: To the be | est of my knowle | edge, death | occurred at the t | ime, date and plac | e, and due to the | e cause(s) and | mannar as s | itatad. |
| | in 24 in Platei | | (Check only 2[| Madical Exam | iner: On the bas and manne | ls of examinetio r stated. | n end/or Inve | estigation, In my | opinion, death occ | urred at the time | , date and place | a, and due t | o the ceuse(s) |
| | With: To the | Σ | 29b. Signature and tit | of pertifiar | 4 | 100) | | 29c. Licen | se number | 4 | 29d. Date sign | | |
| | | | 30. Name and address | s of person who | completed cause | | | | | | | | _ |
| | | | Eddie Na | 54-44 | | | | laney V | alley Rd | ., Timo | nium, M | MD 21 | 093 |
| | Sta Registr | | 31. Date filed (Month, | APR 2 2 | | pistra s Signatu | re / | 9. 600 | uls | | | | |
| | ricgisti | SIT . | | APKAA | 1333 | 6 | - | - 11 2 | | | | | |

3 0

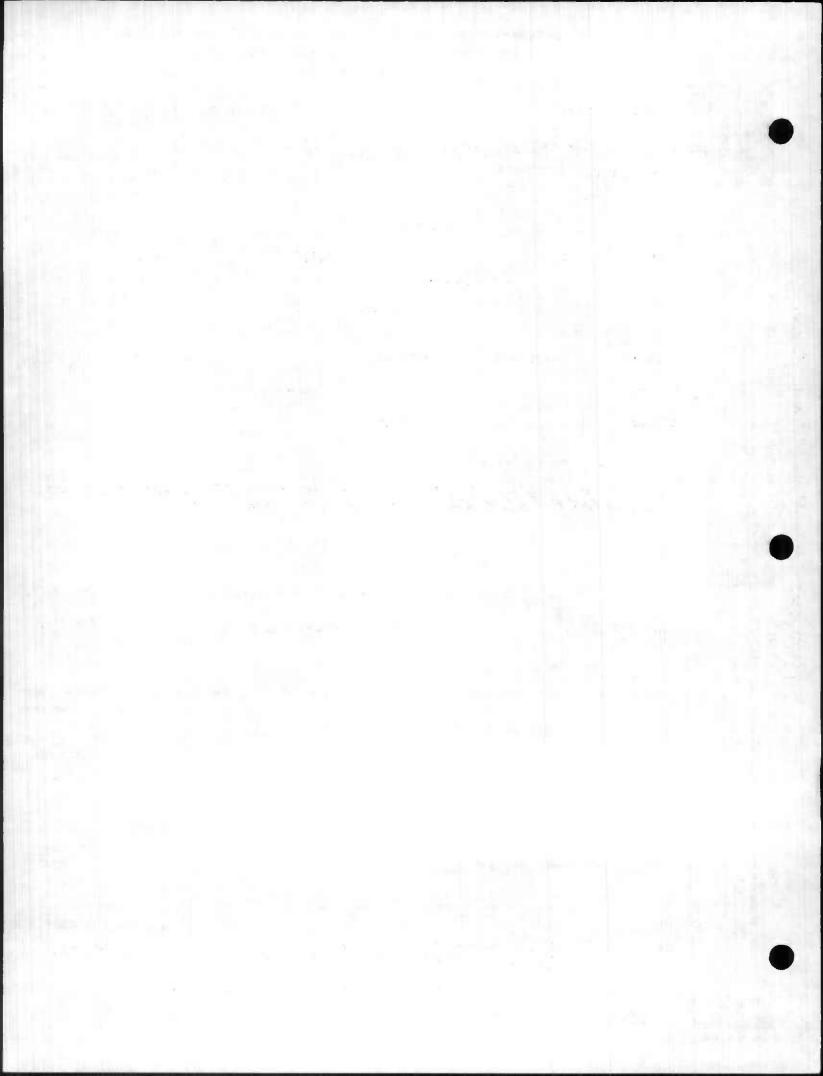


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State of Maryland / Department of Health and Mental Hygiene 9 9

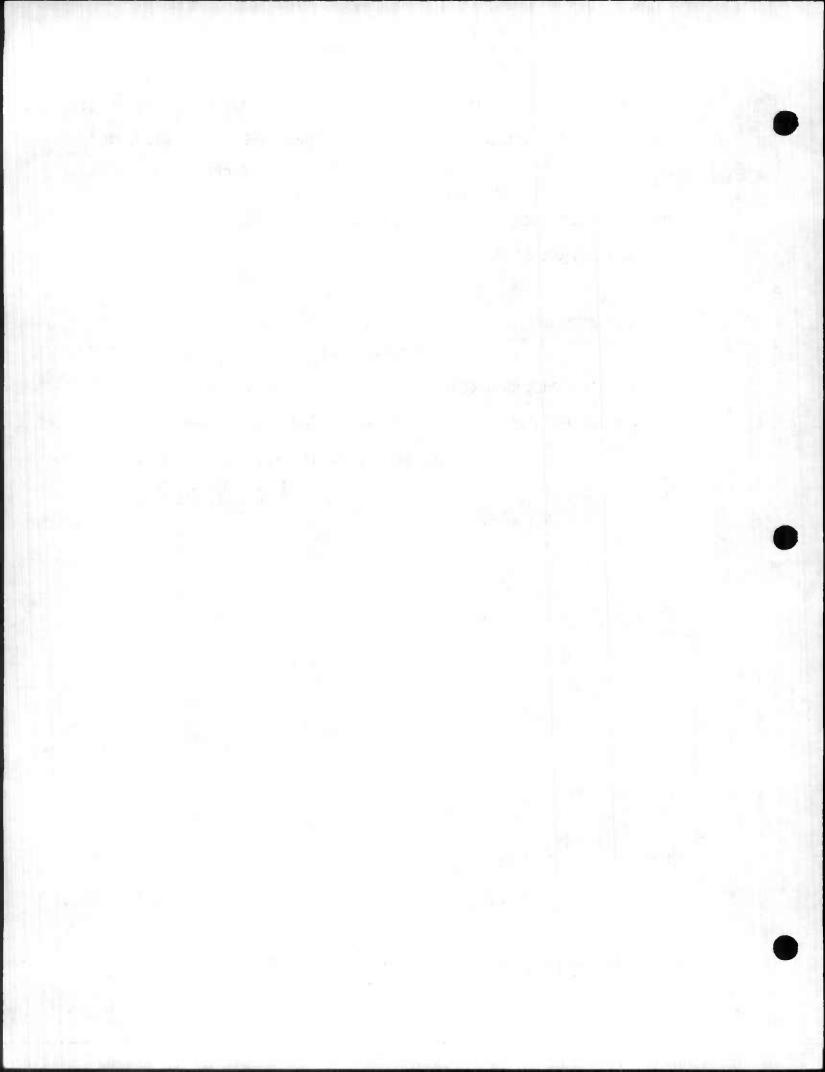
Certificate of Death

| | | | | UE | HIIIC | ale UI | Dealli | 1 | Reg. No. | | T |
|---------------------------------|--|--|--------------------|-------------------|-------------------|--------------|--|--------------------------------------|-----------------------|------------------------------|---|
| Physician | 1. Decedant's Name (First, Middle, L | | | | | | | 2. Date of D Month | Day | Yeer | 3. Time of Death |
| /Medical | Reinal Rigal | | harl | | | | 4b. City. Town, or L | APRIC | | 1999 hty of Death | 0255 |
| Examiner | 4a Facility Name (If not institution, g | | | | | | | | 4c. Cou | ity or Death | |
| | 5 (NA) 405P/1 5. Social Security Number 6. | Sex 7 | BALT Ann In urs | l MOR |) If Unc | der 1 Year | BALTIM If Under 24 Hrs. | R Date of B | irth | 0 Ridho | lana (State or Foreign |
| Funeral Director | 430-45-9666 | 1∑M 2□F | | 61 Yrs. | Month | ns Days | If Under 24 Hrs. Hours Min, | (Month, D | ay, Year) 3, 1937 | Coun | lace (State or Foreign etry) |
| Ctor | Usuel Residence of Decedent | | | | | | | рес. 1 | J, 1937 | ulikile | JWII |
| notified at | 10a. State 10b. County | | 10c. C | ity, Town or L | ocatton | | | | | 1 | 0d. Instde City Limits |
| tor | Maryland | | Ba | ltimor | 9 | | | | | | 1 X Yes 2 ☐ No |
| Director | 10e. Street and Number | | | | | Zip Code | | | 10g. Citizen o | f What Cour | ntry? |
| a | 4601 Pall Mall | Road | | | | 2 | 1215 | | unknow | m | |
| Funeral | 11, Marital Status | 12. Wes Deced | dent Ever in l | J,S. 13. | Was De | cedent of | Hispanic Origin? (Sp ban, Mexican, Puerto | pecify Yes or N | o- 14. P | ace - Americ leck, White, | |
| by Fu | 1 Never Merried 2 Married | 1 Yes 2 | 2 NO | OWII | | | Specify: | ,,,,, | | iy: Hisp | |
| 0 | 3 ₩ Widowed 4 □ Divorced | Year or Da | tes: | | nkno | wn | | | | | |
| Completed | 15. Decedant's (Specify only highest g | Education rade completed) | | 16a. Deci (Giv | edent's U | work done | pation during most of work | king | 16b. Kind of | Business/Inc | dustry |
| E | Elemantary/Secondary (0-12) | Collaga (1- | 4or 5+) | | | Tuse retin | 90) | | | | |
| ပိ | unknown 17. Father's Neme (First, Middle, Las | unknown | | unkno | Wn | | 18. Mother's Nem | ne /First Middl | unknow | | |
|) Be | unknown | ,,, | | | | | unknown | (, ,, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,, | o, maioon com | 2 | |
| 70 | 19a. tnformant's Name/Relationship | (Type Print) | | 19h Mai | ting Addr | ace (Strac | of and Number or Ru | ral Route Num | her City or Toy | n State Zin | Codel |
| | unknown | (1) 10 11 11 11 11 11 11 | | unkn | | 200 (0.100 | | | son, only or vo. | m, orano, asp | |
| other traumatic event, To Be C | 20a. Method of Disposition | | 20b. | Place of Disp | osition (A | Vame of | | Data | 20c. Locatio | n - Ctty or To | own, State |
| | 1 Burial 2 Cremation 3 4 Donetion 5 X Other (Spec | Removal from S | tate | cemetery, cri | ema <i>tory</i> c | or otner pi | ace) | | | | |
| | 21. Signature of Funeral Service Lic. | | ce | 2 | 22. Name | and Addr | ess of Facility | | | | |
| DDCe. | Ronald S. | Wade 12 | irecto | | | | tomy Board | | | imore | Street |
| | 23a, Perf 1. Enter the disease, of co | molications that ca | used the dea | th. Do not er | alti | more | Maryland | 1 2120 | 1 arrest | | Approximate |
| ician | 23a. Perf1. Enter the disease, of co shqck, or heart failure. List onl | y one ceusa on ea | ich tine. | | | | | | | | Interval Between Onset end Death |
| dical | Immediate Cause (Final | | · C · G . | 00:0 | | | | | | | |
| ner | disease or condition rasulting in death) | a | SEI | or as a conse | naugnee (| nf\. | | | | 1 | |
| je la | | C 6 | | | | | ENCE | Dilai. | OVATIA | 2 | 14 DATS |
| n/Medical Examir | Sequentially list conditions, | b. 3.2 | | or as a conse | | | 12/2 | FIFE | 1010101 | | 1 10/11/2 |
| ũ | Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Causa (Disease or trijury that initiated evants | . 5/1 | PC | ARDI | AC | A | 21257 | | | | 14 DAYS |
| n/Medicai Examiner | that initiated evants resulting in death) Last | 6. | | or as a conse | | | | | | t | |
| Me | | d | | | | | | | | | |
| | | | | | | | | | | | |
| y Physician | Part II. Other significant conditions | contributing to dea | ath but not re | sulting in the | underlyin | g cause g | ivan in Part I. | | | | the cause of death? |
| F | | | | | | | | 10 | Yee 2□ No | 3 Pro | bably 4 Unknow |
| d b | | | | | | | | 24a. We | s en autopsy | 24b. W | ere autopsy findings |
| 010 | | | | | | | | per | lormed? | ev | ailable prior to mpletion of cause death? |
| Completed by Physicia | | | | | | | | | Iva alor. | | |
| C | 25. Was casa raterred to medical | | | | | | 00 01 10 | | Yes 2 No | 11 | Yes 2 No |
| To Be | exeminer? | Hospital: | patient 2 |] ER/Outpatie | ant 2 | DOA O | 26. Placa of Dea | | ona) sidence 6 🗆 (| Other /Specif | (v) |
| E | 27. Manner of Death | 28a. Data of (Month | | 28b. Time | | 28c. Inju | | | how injury occ | | 77 |
| atio | 1 Natural 5 Panding 2 Accidant Investigati | | , vay rear) | tnjury | М | | ork?]Yes 2 No | | | | |
| Hick | 3 Suicide 6 Could not datermine | d 28e. Place o | of Injury - At h | noma, farm, s | traet, fact | tory, office | i | | (Street and Nu | m <i>ber</i> or Rurs | al Route Number, |
| Cer | - La i rottiloud | Duliding | g, etc. (Speci | ny) | | | | Only of Th | on, olale) | | |
| edical Certification: | | | | | | | ime, date end place opinton, death occu | | | | |
| | one) 2 Medical Ext | and manne | | ation and/of I | ivastigati | on, in my | opinion, gaath occu | II BU BI IME | | | |
| Σ | 29b. Signature and title of certifier | - | | | | 29c. Licer | se number | | 29d. Date sig | ned (Month, | Day, Year) |
| | 109 | 16 | 200 | 3/11 | 0 | PI | 2340 | | APR | 16 15 | 1999 |
| | 30. Name and address of person who | completed cause | of death (Ita | m 23a) (Type | , Print) | | 10 | | | | 11. |
| | SINAL HOSPITALO | EBALTIMO | 11.24 | 101 W. | BELL | epse | EAUX, BAL | TIMORA | MDZ | 1215 | |
| State | 31. Date filed (Month, Day, Year) | 22. Re | gistrar's Sign | nature | 1 | | | | | | |



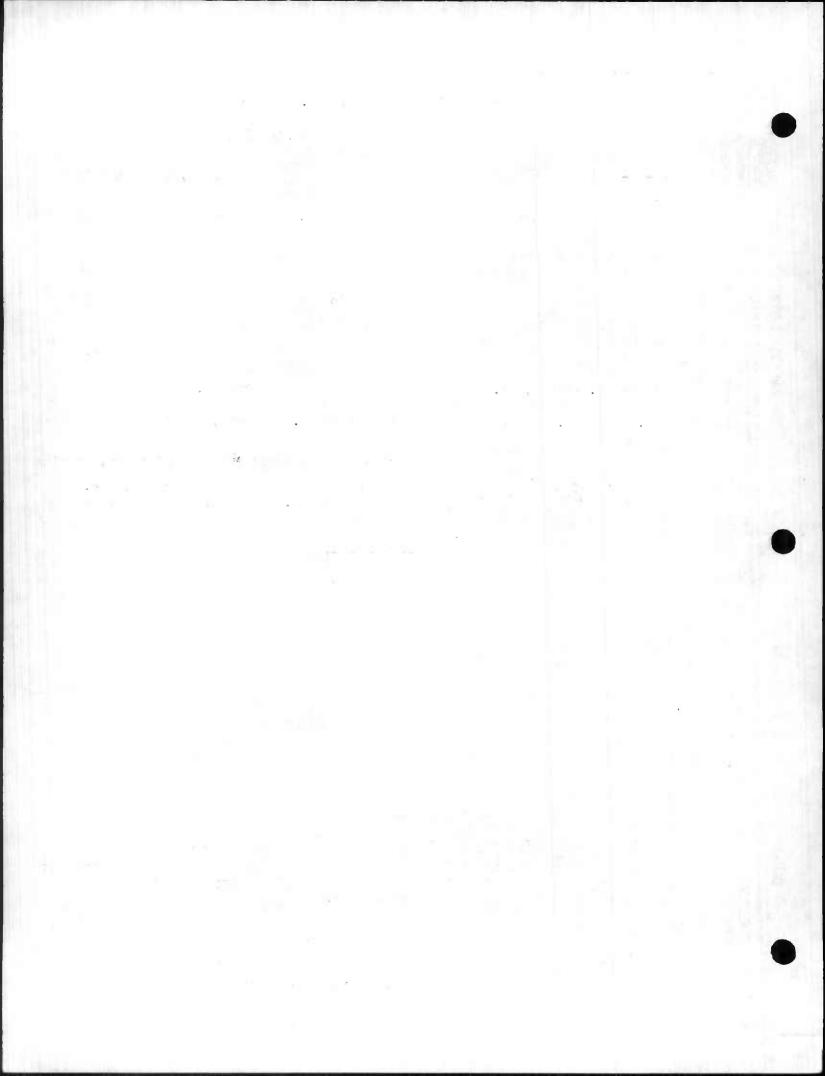
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| | Decedent's Name (F. | iret Mirkla I set | | | Cer | tifica | te of l | Death | 2. Date of D | Reg. No. | 9 | 3, Time of Death |
|-------------------|--|-------------------------|--|-------------------------|---------------------|-----------|-------------------------------|--|-------------------------------------|-----------------------------------|-------------|---|
| sician | Josep | allice and and | | smar | rino | | | | Month | Day | Year 999 | 0-00 |
| edical | 4a Facility Name (If no | | | | | | 4 | b. City, Town, or | April Location of Dea | | | 2:30 a.m. |
| iminer | 7837 E. B | | | | | | | BALTIMO | RF | | | |
| eral | 5. Social Security Numb | | | ge (In yrs. | . last birthday) | | or 1 Year | If Under 24 Hrs | 8. Dete of B | irth . | 9. Birthp | olace (State or Foreign |
| | 214-14-3278 Usuel Residence of Dec | | 0 ⁸ M 2□ F | 82 | Yrs. | Months | Days | Hours Min | April 1 | BALT: | MAR | YLAND |
| L | 10a. State 10 | b. County | | 10c. C | ity, Town or Loc | | | | | Sur . 7 | 1 | 1 ☐ Yes ②(XNo |
| 5 | MD. | BALTIMO |)RE | | BALT | 1 | | | | | | |
| Director | 10e. Street and Number | | | | | 10f. Z | p Code | | | 10g. Citizen of W | hat Cour | ntry? |
| Funeral | | ALTIMORE | | | | | 212 | | | u.s.a. | | |
| Dy rulle | 11. Marital Status 1 Never Married 3 Widowed 4 | 2 Married | 12. Wes Decedent Armed Forces? 1 Decedent 1 Decedent 1 Yes, Give Year or Dates: | No | H | | edent of Hecify Cuba 2XXXX | ispanic Origin? (S n, Mexican, Puer Specify: | ipecity Yes or N to Rican, etc.) | Blec | HITE | |
| | 15. | Decedent's Edu | cation | MM | | ent'a Usi | ual Occup | ation | | 16b. Kind of Bu | | |
| | (Specify o | nly highest grad | e completed) | F.\ | (Give life. D | and of w | ork done d use retired | ation furing most of wo) | rking | | | |
| Completed | 8 | y (0-12) | College (1-4or | 3+) | ASSEN | MBLY | LINE | | | GENERAL | MOT | ORS |
| | 17. Father's Name (Firs | t, Middle, Last) | | | - 11000 | | | | me (First, Middle | e, Maiden Sumem | | 0110 |
| | JOSEPH CI | | | RINO | 1 | | | CARME | | KNOWN | | |
| | 19a. Informant'a Neme | CHEST DESCRIPTION | | | | | | | | ber, City or Town, | | Code) |
| | GERI B. SOL 20a. Method of Disposit | | HIEK | 20h | 298 II | | | E., SAN | _EANUKU, | CA. 9457 | | num Ctoto |
| | 1 Burial 2 XX | | emoval from State | | cometery, crem | atory or | other plac | 1 | | | | |
| | 4 ☐ Donation 5 ☐ | | | GF | REENMOU | | | | 17/99 | BALTIMO | RE, M | ARYLAND |
| | 21. Signeture of Funera | I Service Licens | Bud | D | LII 190 | LLY | & ZEI | LER INC N AVENUI | FUNERA BALTIN | AL HOME MORE, MARY | LAND | 21231 |
| | 23a. Pert1. Enter the di shock, or heart fei | sease, or compli | cations that ceuse ne cause on each li | d the dea | th. Do not ente | | | | | | | Approximate Interval Between |
| | Immediate Cause (Fine disease or condition | 1 | los | sill | Acut | L M | , | | | | | 1-2 Hrz |
| Jer | resulting in death) | | W | Due to | or as a consequ | | | | | | 1 | 4-11 |
| Examiner | Sequentially list condition of the condi | ons, diate | 0 | | or as a consequ | ence of |): | | 0 | | | |
| edical | Cause (Disease or injur thet initieted events resulting in death) Last | | | Due to (d | or es e consequ | ence of | reso | Hero | ua L | my. | | 2 beels |
| Physician/M | | | l | | | | | | | | 1 | |
| 80 | Part II. Other significan | t conditions con | tributing to death b | ut not res | sulting in the un | derlying | ceuse giv | en in Part I. | 23b. Dic | tobacco une cor | tribute to | o the cause of death |
| טא רוווא | | | | | | | | | 10 | Yea 2□No | 3 Pro | bably 4. Unknow |
| Completed | | | | | | | | | 24a. We per | s en eutopsy formed? | av | ere autopsy findings railable prior to empletion of cause death? |
| 5 | | | | | | | | | 10 | Yes 22 No | 10 | Yes 22 No |
| Ŭ | 25. Was case referred t | o medical | | | | | | 26 Place of De | ath (Check only | | | 2,210 |
| 00 | examiner? | - | lospitat: | | ER/Outpatient | 200 | Oth | DATE: | | sidence 6 Othe | on (Conneil | 4.1 |
| Certification: To | 27. Manner of Death | Pending investigation | 28e. Date of Inju | | 28b. Time of Injury | | 28c. Injun Worl | | Y | how injury occurr | | 79) |
| | 3 Suicide 6 4 Homicide | Could not be determined | 28e. Place of Injuding, et | ury - At h c. (Speci | ome, ferm, stre | et, facto | ry, office | | 28f. Location City or To | (Street and Number own, State) | er or Aure | al Route Number, |
| edicai | | | ician: To the best her: On the basis of and manner st | examina | | | | | | | | |
| Σ | 29b. Signeture and title | of certifier | | | | 29 | c. License | | | 29d. Date signed | | |
| | | | | > | | | PI | 422 | / | 4.1 | 6. | 59 |
| | 30. Neme and address of | / / | mpleted cause of d | leath (Iter | m 23a) (Type, P | Print) | 13 4 | 0 60 | 1 LT a | 0 2/2 | 2/ | |
| | 31. Date filed (Month, D | and Maria | 32. Registr | and Cinn | -Arana | | | | | | | |



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| #23 PART I, 27, 28A- | st) | 70 4-2 | /99 | | | 2. Dete of Dec | Reg. No. | 3. 1 | ime of Death |
|---|--|--|--|--|--|---|--|--|--|
| . December 1 man in many Las | | | | | | | 17, Day 1999 | | :42 PM. |
| a Facility Name (If not institution, give | e street and number) | | | | 4b. City, Town, or | | | | |
| 37 OLD KNIFE | CT. | | | | Middle | River | BAI | TIMORE | |
| 213-17-5117 | | e (In yrs. las 22 | | | | . (Month, Da | | 9. Birthplace (Country) Maryl: | Stete or Foreign |
| | | 10c. City. | Town or Location | n | | | | 10d In | side City Limits |
| | altimore | | | | Dundalk | | | | Yes 2∰No |
| | | | 10 | Of. Zip Code | | | | | |
| | | Ever in II S | 13 Was | Decedent of H | | Specify Yes or No. | | | |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? | | | | | rto Rican, etc.) | | k, White, etc. | nite |
| 15. Decedent's Ed | fucation de completed) | | 16a. Decedent's | s Usual Occup | pation during most of we | orkina | 16b. Kind of Bu | usiness/Industry | |
| Elementary/Secondary (0-12) | | 5+) | | | d) | | | | |
| 7 Father's Name (First Middle Lest) | | | Labo | rer | 19 Mather's Na | me /First Middle | | | n |
| | | | | | | | | , | |
| | | ner | 19b. Meiling Ad | dress (Street | | | | State. Zip Code |) |
| | | | | | | | | | |
| On. Method of Disposition | | 20b. Pla | ce of Disposition | (Name of | | Dete | | | tete |
| | | | | | | /1999 | Balti | more. Ma | arvland |
| | 0.1.1. | Joan | 22. Na | me end Addre | ass of Fecility | | | | aryrana |
| 1 / St. 1/ | W. Non | nine | | | | | | • | 2 |
| 23a. Part1. Enter the disease, or conf | plications that caused | I the death. | | | | | | Appr | oximate |
| disease or condition | a. | | | | ON | | | ! | a and Deem |
| | b | Due to (or e | e a consequent | o off: | | | | 1 | |
| lany, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events | c | | | | | | | | |
| esulting in death) Last | d | | | | | | | | |
| art IL Other significant conditions of | ontributing to death b | ut not resulti | ing in the under | ying cause giv | ven in Pert I. | 23b. Did 1 | obacco usa co | ntribute to the | cause of death? |
| | | | | | | 10 | Yas 2□ No | 3 Probably | 4.27 Unknown |
| | | | | | | | | eveilable | ion of cause |
| | | | | | | 1,27 | res 2 No | 1 27 Yes | 2□ No |
| | | | | | 26. Place of De | eeth (Check only o | ne) | | λm |
| 1 No 2 No | | | R/Outpatient 3 | DOA Oth | ner: 4 Nursing | Home 5 Resid | dence 6XXX | er (Specify) | SCENE |
| 1 Natural 5 Pending | (Month De | v Voerl | Injury | 28c. Injur Wor | y at rk? Yes 2⊠No | | | | DOMAG |
| 2 ☐ Accident 3 ☐ Suicide 6 ☒ Could not be | 4-1 | /=99 ury - At hom | 6:39 | | | | INGESTED Street and Numb | | te Number, |
| determined | 28e. Place of Injuding, etc. | | | ,, | | | Street and Numb vn, State) 37 | | COURT |
| 4 Homicide determined | COL | IND IN H | | urred et the tir | me, date and place | | E COUNTY cause(s) and ma | anner es stated. | 5.00 |
| 4 Homicide determined 9a. Certifier 1 Certifying Ph | ysician: To the best | | | | | curred at the time | | and due to the | euse(s) |
| 9a. Certifier (Check only one) determined determined 1 Certifying Physics 2 Medical Example | | examination | | getion, in my o | opinion, deeth occ | | date and plece, | | |
| 4 Homicide determined 9a. Certifier Check only 2 Medical Exam | ysician: To the best of | examination | | | opinion, deeth occ | | date and plece, 29d. Dete signe | d (Month, Dey, | |
| 9a. Certifier (Check only one) 1 Certifying Physics Medical Examples 9b. Signature and title of certifier | yelclan: To the best of the state of the sta | examination ated. | n and/or investig | 29c. Licens | opinion, deeth occ | | date and plece, | d (Month, Dey, | |
| 9a. Certifier (Check only one) 1 Certifying Physics Medical Examples 9b. Signature and title of certifier 0. Name and address of person who determined | yelclan: To the best of the state of the sta | eath (Item 2 | M D (Type, Print | 29c. Licens | opinion, deeth occ se number O.C.M.F | | date and plece, 29d. Dete signe APRIL 1 | d (Month, Dey, 8, 1999 | |
| | 37 OIJD KNIFE 5. Social Security Number 213-17-5117 Jeual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 6528 Riverview 11. Marital Status 11 Never Married 12 Never Married 15. Decedent's Ec (Specify only highest grave) Elementary/Secondary (0-12) 12 Years 17. Father's Name (First, Middle, Last) Richard A. Rink 19a. Informant's Name/Relationship (Mrs. Pattie S. 20a. Method of Disposition 13 Decedent's Ec (Specify only highest grave) 15. Decedent's Ec (Specify only highest grave) 16. Support on Specific only highest grave) 17. Father's Name (First, Middle, Last) Richard A. Rink 19a. Informant's Name/Relationship (Mrs. Pattie S. 20a. Method of Disposition 15 Doyling Specific only 23a. Part I. Enter the disease, or confident only 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last 25. Was case referred to medical examiner? | As Facility Name (# not institution, give street and number) 37 OIJD KNIFE CT. 5. Social Security Number 6. Sex 213-17-5117 Jeual Residence of Decedent 10a. State 10b. County Maryland 10c. Street and Number 6528 Riverview Avenue 11. Marital Status 12. Wes Decedent 1 Marital Status 13. Weso Married 1 Mever Married 2 Married 1 Mever Married 2 Married 1 Mever Married 2 Married 1 Meyer of Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years 17. Father's Name (First, Middle, Last) Richard A. Rinker, Sr. 19a. Informant's Name/Relationship (Type, Print) Mot) Mrs. Pattie S. McGehee 20a. Method of Disposition 1 Humal Cremetion 3 Removal from State 1 Dogman 5 Other (Specify) 21. Segature of Funeral Service Secure on each life in any, leading to immediate Cause (Finel disease or conditions esseling in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Cause Disease or Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause (Finel Cause Cause Cause (Finel Cause Cause Cause (Finel Cause Cause Cause Cause (Finel Cause Cause Cause Cause Cause Cause Cause Cause Cause Cause Cause Cause Cause Cause C | Second S | Table 1 Second Security Number Security Nu | Table 1 Name (if not institution, give street and number) 37 OIJD KNIFE CT. Social Security Number 213-17-5117 Seculal Security Number 18 M 2 F 22 Yrs. 18 M 2 F 22 Yrs. Months Deys 213-17-5117 19 Secular Sesidence of Decedent 10 State 10 County Maryland Baltimore 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 11 City Security 12 Wes Decedent Ever in U.S. 13 Wes Decedent of In Yes, specify Cuty 14 Yes, specify Cuty 15 Peccedent's Education (Specify only highest grands completed) 16 City Security 17 Security 18 City Security 18 City Security 19 City Security 19 City Security 10 City Security 10 City Security 10 City Security 10 City Security 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 10 City, Town or Location 11 Was 2 EN 11 Yes, specify City 11 Yes, specify Cuty 11 Yes, Specify Cuty 12 Yes, Specify Cuty 12 Yes, Specify Cuty 13 Wes Decedent of In Yes, Silve 14 Yes, specify Cuty 14 Yes, specify Cuty 15 Decedent's Usual Occur 16 City Security 16 City Security 16 City Security 16 City Security 16 City Security 16 City Security 16 City Security 16 City Security 17 Security 18 Mes Decedent of Inty Security 18 Wes Decedent of Inty Security 19 City Security 10 City Security 10 City Security 10 City Security 10 City Security 10 City Security 10 City Security 10 City Security 10 Cit | A Countries of the properties | Seculity Name (if not institution, give street and number) 37 OLD KNIFE CT. 4b. City, Town, or Location of Death Middle River 37 OLD KNIFE CT. 4b. City, Town, or Location of Death Middle River 323—17—5117 120 | as Facility Name (if not institution, give street and number) 37 OLD KNIFE CT. 6. Sax 21.3—17-5117 10. Castal Security Number 21.3—17-5117 10. Castal Security Number 10. County Maryland 10. County Maryland 10. County Maryland 10. County Maryland 10. County Maryland 10. Castal Status 10. State 10. St | as Facility Names (if not institution, give attend number) 3 O I.D. KNIFE CT. 3 O I.D. KNIFE CT. 180 M 2 F 7 Age (in yes, last beforekey) 180 M 2 F 7 Age (in yes, last beforekey) 213-17-5117 21 Jausal Residence of Decoders 180 M 2 F 7 Age (in yes, last beforekey) 213-17-5117 21 Jausal Residence of Decoders 180 M 2 F 7 Age (in yes, last beforekey) 21 Jausal Residence of Decoders 180 M 2 F 7 Age (in yes, last beforekey) 21 Jausal Residence of Decoders 180 M 2 F 7 Age (in yes, last beforekey) 21 Jausal Residence of Decoders 180 M 2 F 7 Age (in yes, last beforekey) 21 Jausal Residence of Decoders 3 Decoders of Number 3 Daniel State 3 Daniel State 3 Daniel State 3 Daniel State 3 Daniel State 3 Daniel State 3 Daniel State 4 Daniel Stat |



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death April **Physician** 21 1999 KOLFES ANNA 7:30 AM TARIE /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Arundel Road Pasadena Anne South If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 2, 1925 Birthpiace (State or Foreign Country) 5. Sociei Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Days Hours Min 74 Yrs. 218-18-6364 Maryland **Director** Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalith and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examines must be notified as once. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21122 1205 South Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married White 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Forklift Wire Production Operator 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Williams Helen Bittner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Christine Barnickel / Daughter 1205 South Rd. Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Denetion 5 □ Other (Specify) Glen Haven Memorial Park 4/23/99 Glen Burnie, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2719 Hammonds Ferry Rd. Lansdowne, Md. 21227 Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final nonsmall cell ling cancer disease or condition resulting in death) 4000 Examiner Due to (or as a consequence of). Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be datached 1 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy director, page 2 s 1 Yas 2 No 1 □ Ves 2 □ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

APR 2 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erkman

32. Registrar's Signature

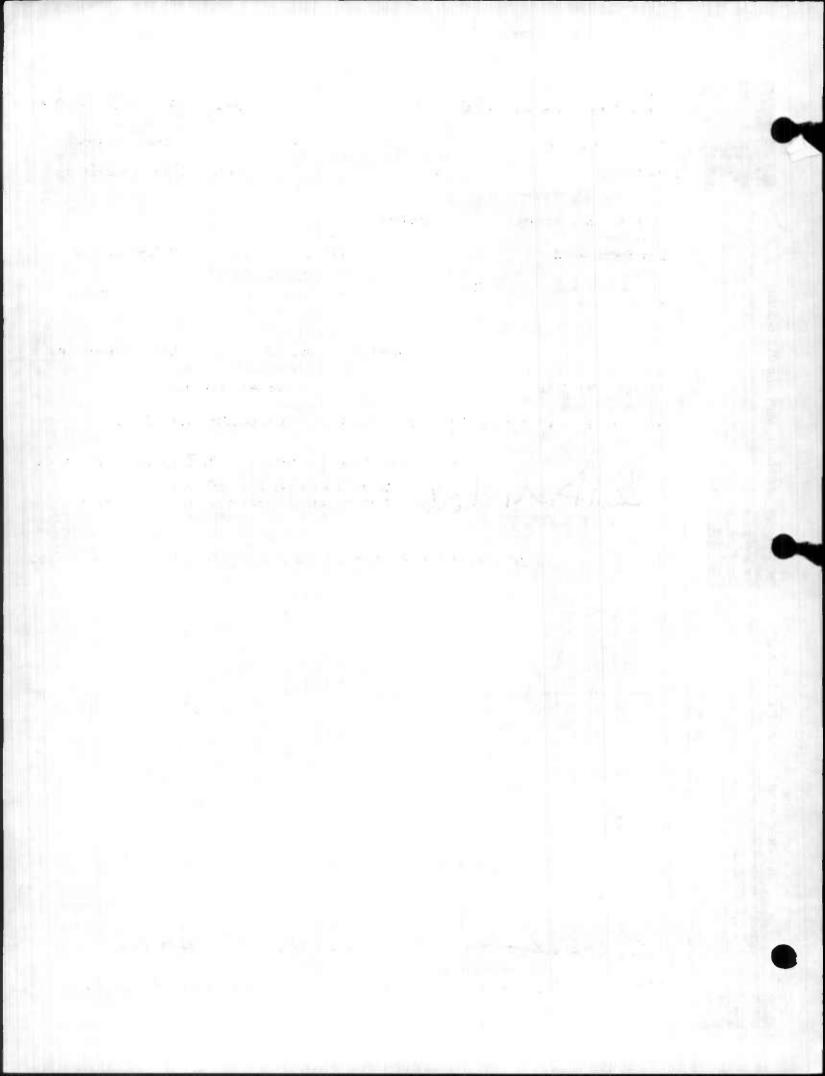
mo

3001 S. Hanover St, Baltimore, Med 21230

29c. License number

1122782

29d. Dete signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1 Decedent's Neme (First Middle Last) 2 Date of Death Month **Physician** 19:25 Riggio 100 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give and number) Examiner Maryland Baltimax If Under 24 Hrs. N/A inter 1 Year Medical university 9. Birthplace (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Deys Yrs. **Director** 214-22-5470 27 . . Nov Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Westview 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1502 Adamsview Road. 21228 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Status permit. Peges 1 end 2 should be filed within 72 hours after of Depertment of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Experimental. 1 ☐ Never Merried 2 Married N Yes 2 No WYes, Give Yeer or Detes: WWII altimore, Maryland 21215-0020 1 Yes 2 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Ironworker Ornamental Rod Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pietro Riggio Grace (Chomighani) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 1502 Adamsview Rd. Catonsville, MD 21228 Laura Riggio/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 Dother (Specify) Intombmnt Crestlawn Mem. Gard4/23/99 Marriottsville MD 21. Signeture of Funerel Service Licensee Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, MD21228 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Preumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificete be axecuted attending physician end for use es the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es e consequença of) Box 68760, Due to (or es e consequence of): resulting in deeth) Lest Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the a 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Radiation Fibrasis þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen certificata has 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical exeminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2 No 2 ☐ ER/Outpetient 3 ☐ DOA 15 Inpatient : After this of funeral dir 27. Menner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28h. Time of Certification: 28c. tnjury at Work? 5 Pending Investigation 1/ Naturel within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Cartifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mme

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Greene 32. Registrar's Signature

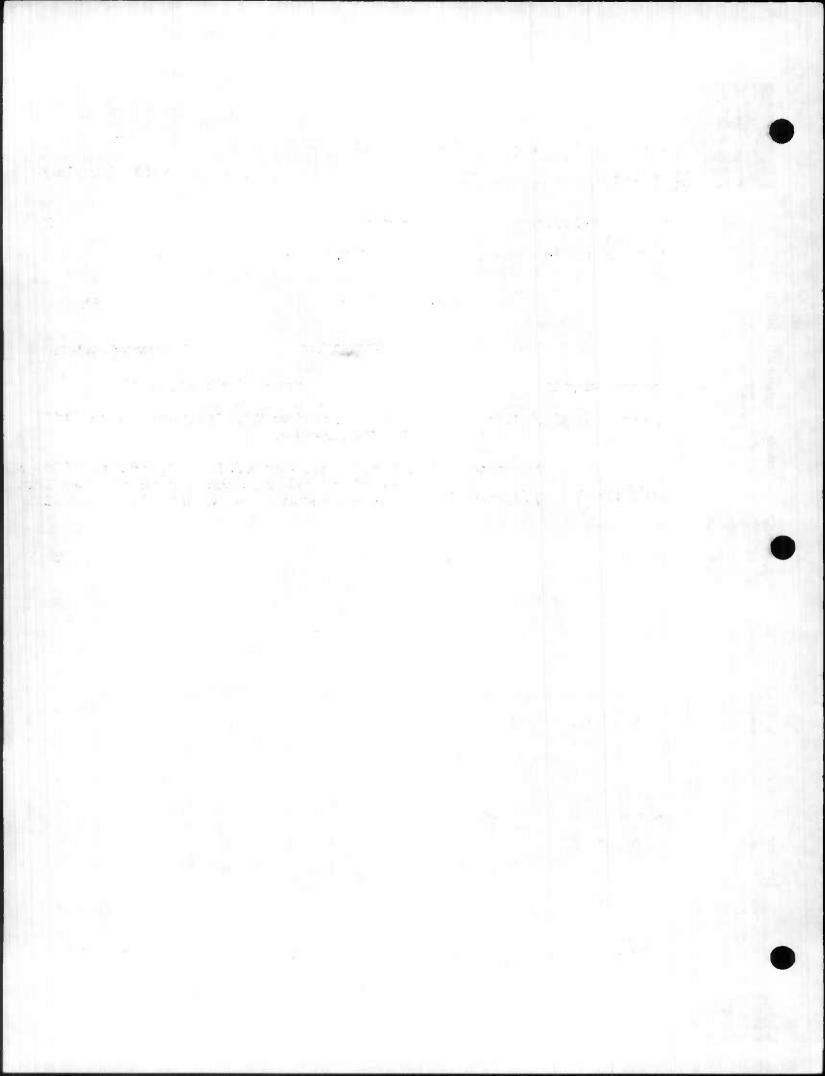
Street

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Anne

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 70, **Physician** 7 1999 4c./County of Deat /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 22 S Groan Examiner 8. Date of Birth (Month, Day, Year) R. Adams Gwley Shack Tray Cuts

5. Social Security Number 6. Sex 7. Age (In yrs. last bit BAHOMH NA 5. Social Security Number 7. Age (In yrs. last birthdey) if Under 1 Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 255 Hours 18 Director 220-13-0190 Usual Residence of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b County 10d Inside City Limits th and Mantal Hygiene.
7 is marked other than "natural", or flems 23a or 28a-f show traumstic event, the Medical Examinet must be notified at 1 ☐ Yes 2 No PERRY HALL Director BRLTIMORE Md 10g. Citizen of What Country? 10e. Street and Number C IRCLE 21236 USA 3734 MAHOE Funerai 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian, 11. Maritel Stetus Biack, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNo Specify: Specify: WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) BLAKE HURST CO th RECEP1 2 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be DONALD E. RISNER SUSAN R. REMORTEL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) end 2

Important: If them 27 is a sary injury or other 1-Md DONALD & SUSAN RISNER / PARENTS 3734 PERRY HALL 21236 TIMAHOE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete Buriai 2 Cremetion 3 Removel from State 4/22 4 ☐ Donation 5 ☐ Other (Specify) MEM, MORELAND 22. Name and Address of Facility //ER 21. Signetule of Funeral Service Licensee FUNCEAL BA 21234 49 ROORD 23a. Part. Enter the diseasa, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deetl **Physician** /Medical Immediate Cause (Finai disease or condition resulting in death) Examiner Examiner ettending physician end for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medicai RTIFICATION APPROVED BY MEDICAL EXAMINES Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings svailable prior to completion of cause of death? Completed 24a. Was an autopsy After this certificate has funeral director, pege 2 1 Yes To the Hospital or Attending Physician: within 24 hours efter death. 25. Was case referred to madical examiner?

Yas 2□ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Invastigation Injury 1 Naturai 2 Accident 3 Suicide 1 Tes 2 1 No redestrian Struck by Motor 1932 Place of Injuly - At home, farm, streat, factory, office building, etc. (Spoicity) 6 Could not be determined Funeral Directo ration (Street and Number of Yor Town, Stata) 4601 Rural Routa Number, 4 Homicida Ebenezer Baltimore GUTY, Maryland 1 Certifying Physician: To the bast of my knowladga, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier within 24 hour To the Funer completely fill edicai (Check only one)

29c. License number

Cowla

32. Registrar's Signatur

29d. Date signed (Month, Day, Year)

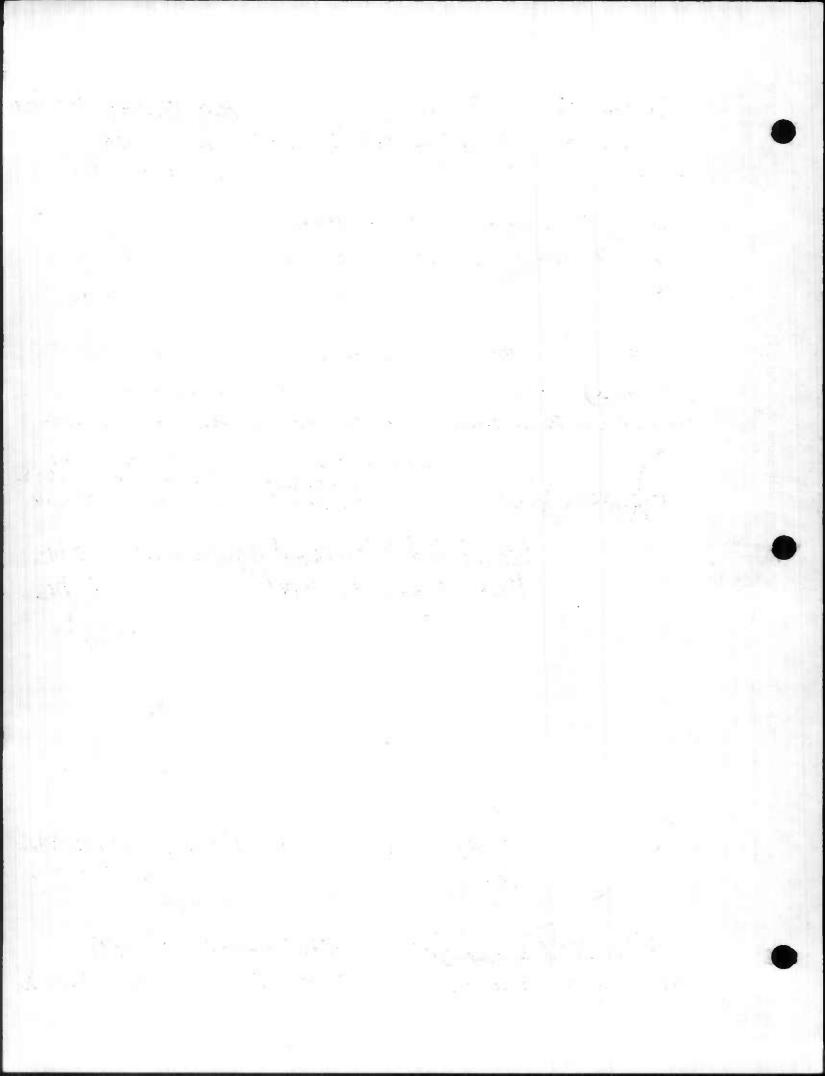
State

Registrar

29b. Signature and title of co

30. Name and addrass of per

31. Date filed (Month, Day, Year)
APR 2 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month F-. LEO REIFSTECK APIZIL 1999 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Rossville Mol BALTIMORE ARE ROSSVILLE MANOR HEALTH If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 □ F 098-18-4328 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTO BALTO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3901 JOPPA Rd 21236 U514 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1. Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMMER. REFRIG RESTURAIOT SUPPCO 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ADAM R. REIFSTECK YENNY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. BALTO Md 21236 VIRGINIA REIFSTECK 3901 TOPPA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Topesi BALTO GARRISON 22. Name and Address of Facility HARTLEY MILLER 21. Signatura of Funeral Service Licensee FUNERAL HOME. CHTD. BALTO 7527 HARFORD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Enter the disease, or , or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final & MO C000 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show items 23a or 28a-f show

6

"natural".

traumatic event, the Medical Examiner

other 1

20

Department of Important: If any Injury or

filed within 72 hours efter

Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. int: If Itam 27 Is marked other than

21215-0020

Baltimore, Maryland

Director

Funeral

Completed by

Be

Physician/Medical Examiner -tran and signed by t by page 2 should Completed After this certificate Be 2 filled in by the funeral Certification: death. efter death

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

10

or Attending Physician:

To the Hospital o within 24 hours eff To the Funeral Di

Medical

1 Yes 2 No 27. Manner of Death 1 Natural
2 Accident

3 Suicide 4 Homicide 29a, Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Telegraphy in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Dey, Year)

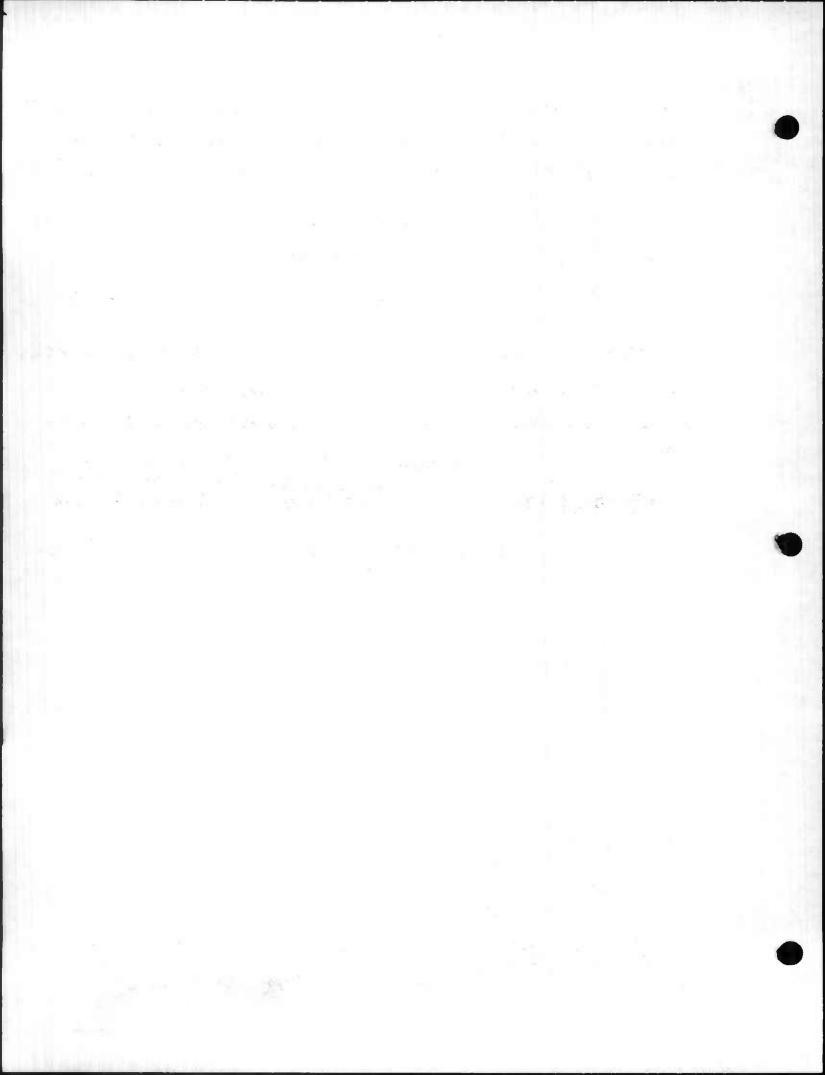
30. Name and address of part d cause of death (Item 23a) (Type, Print)

ichnama 31. Date filed (Month, Day, Year) 221000

121 32. Registrer's Signature 200

Registrar

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** SMOOT)ohn 1999 APMI 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Johns Hopkins more 8. Data of Birth Month, Day, Year) 111NO 16, 1951 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 9. Birthplaca (Stata or Foraign **Funeral** 180 M 2□ F Months Days Hours Min. Marilland 47 212-50-3094 Director Usual Rasidence of Dacedant the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Example must be notified at once. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Directo Maryland Harkord Darlington 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3602 Berkley Road 21034 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Nevar Married 2 □ Married 1 Yas 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) Coliega (1-4or 5+) 11th grade Heavy Equipment Operator Construction 18. Mothar'a Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) John Melvin Smoot. Sr. Anita Dorothy Doffmyer 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2528 Old Robinhood Road. Raynor K. Horton, Jr. (Nephew) Havre de Grace. MD. 21078 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Harford Memorial Gardens 4/19/99 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen. Maryland 22. Nama and Addrass of Facility
Schimunek Funeral Home of Bel Air,
610 W. MacPhail Road, Bel Air, MD. 21. Signatura of Funarai Sarvice Licansee Makel 21014 23a. Part1. Enter the disease, or semplications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner ArdIAC AMMONAD The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to d be detach 3 Probably 4 Unknown 1 Xas 2 No þ 24b. Wara autopsy findings available prior to complation of cause 24a. Was an autopsy performed? Completed certificate has b 1 ☐ Yas 2X No 1 Yas 25€No or Attending Physician: director, 25. Was cesa rafarrad to medicel axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred After Natural 2 Accidant 5 Panding Invastigation 1 Tas 2 No within 24 hours after death To the Funeral Director: / completely filled in by the 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifian Medical (Check only one)

29c. Licansa number

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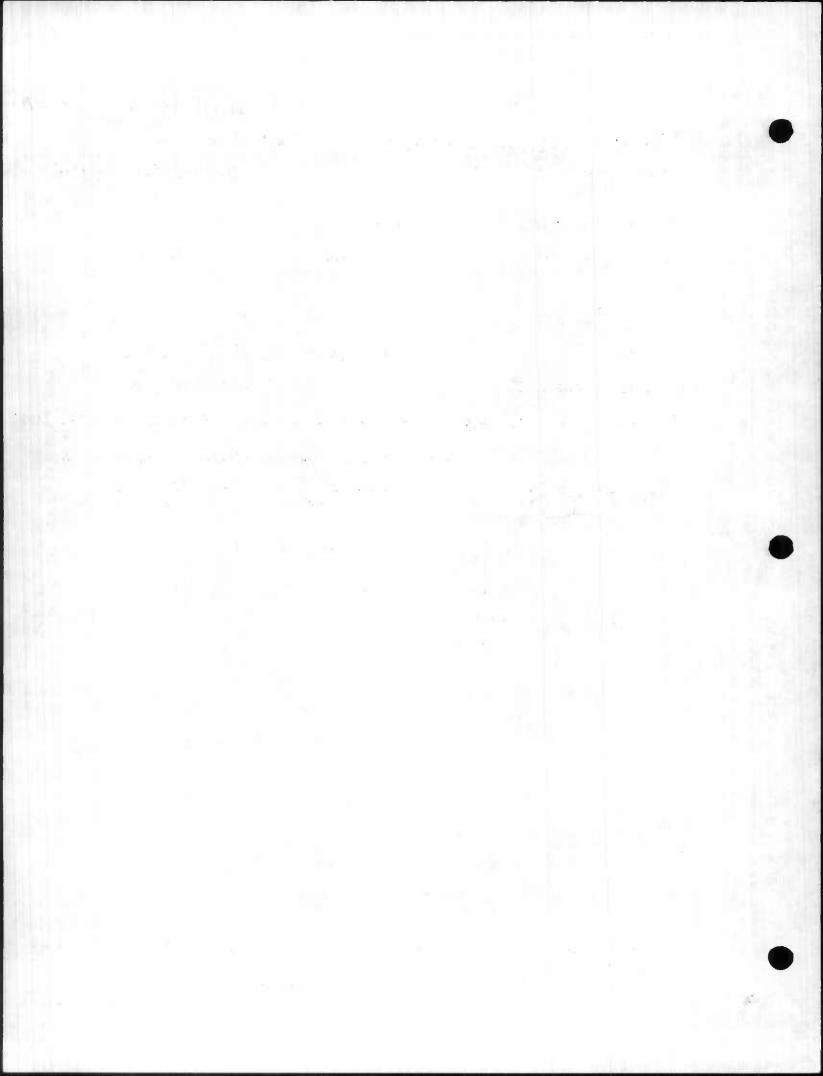
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29d. Data signed (Month, Day, Year)

BANMURE, MD

State Registrar

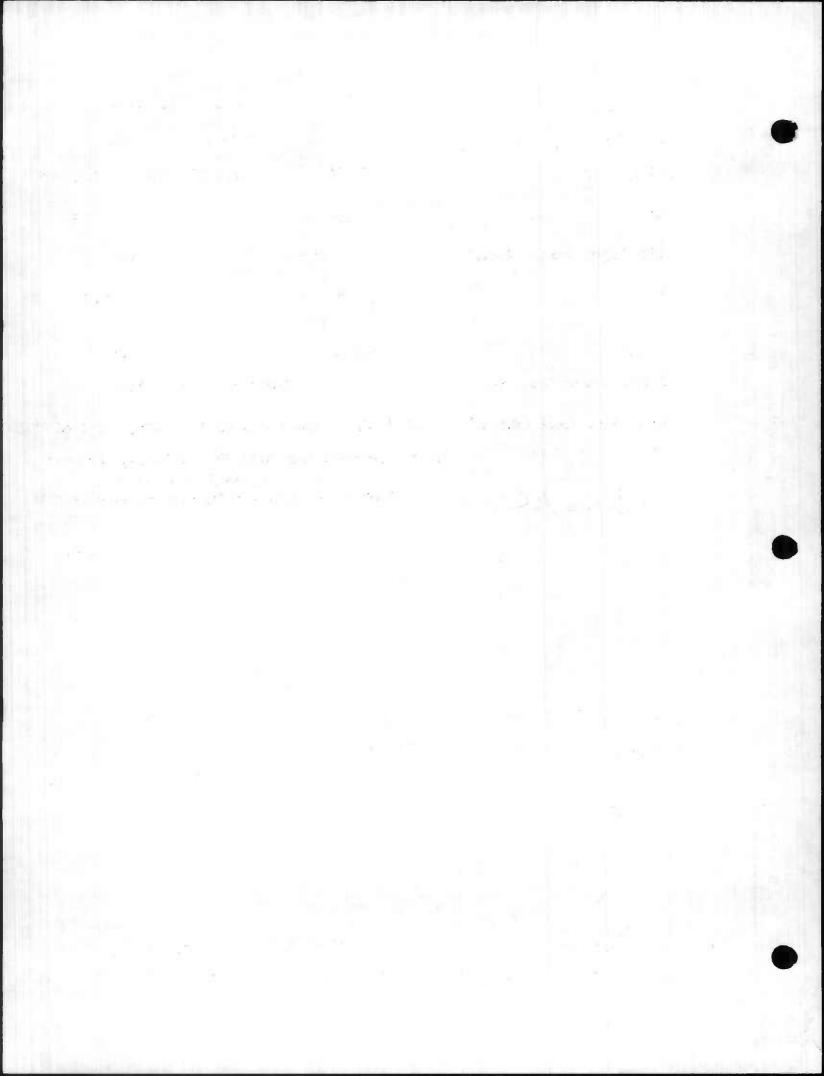
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Scott Year **Physician** Codric DISOAM /Medical 4b. City, Town, or Location of Death
Bult wore City 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins ttospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 06 24 1**∑** M 2□ F Yrs. 216-53-3317 Sept 25, 1998 **Director** Maryland Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at MD N/A 1 Yes 2 No Baltimore Director 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3301 Elgin Avenue Apt.#3 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours efter in and Mental Hygiene. Is marked other than "natural" or item 1X Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A Infant N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cedric Lamont Scott Sr. Roletta Sharron Wilson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 is m Roletta S. Scott (Mother) 3301 Elgin Avenue Apt. #3 Baltimore, Maryland 21216 of Disposition (Neme of Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State injury or Arbutus Memorial Park 4/23/99 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, Maryland 22. Name and Address of Fecility Caple Funeral Service 21. Signature of Funeral Service Licensee any ir 5502 Winner Avenue Baltimore, Maryland 21215 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) 5 Hays Examiner mediastinitis ician end buriel-transit requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use es the bune Physician/Medical Due to (or as e consequence of): 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? pulliative surgery signed by I 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed heart 2 No 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After t Certification: Netural 2 Accident 5 Pending investigation or Attending effer death. Director: Aft 1 Tes 2 No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Mospital of 24 hours e Funersi D to the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated.

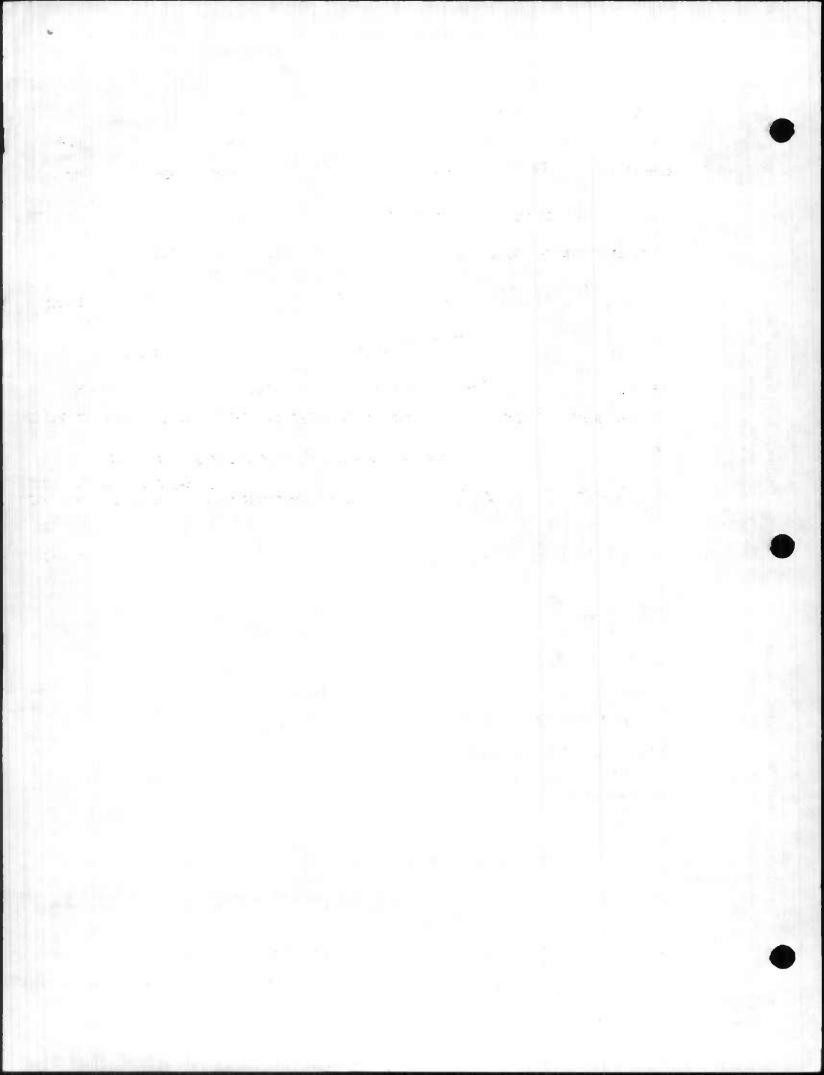
2 Medicat Examiner: On the best of exeminetion and/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the within 2 29b. Signeture inditio of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45068 30. Name and address of person two completed cause of death (Item 23a) (Type, Print)
Hays, ND The Johns Hopkins Hospital Baltimore, MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

NA



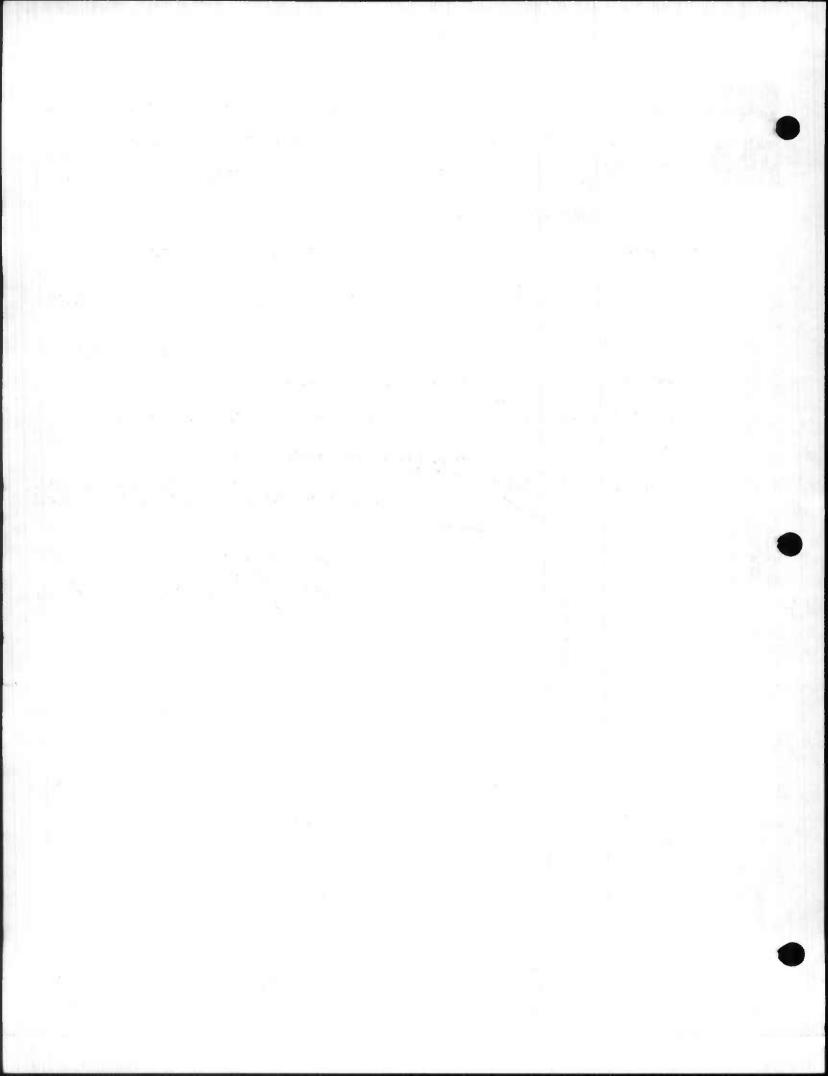
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| 10e. Stete | dence of Deced | | | 10c. City | v. Town or Loc | eation | | | | | 10d. Inside City |
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| MD 10e. Street | end Number | | | | | 10f. Zip Cor | de | | 10g. Citizen of | What Cour | ntry? |
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| | ver Merried 2 | | 1 M Yes 2 If Yes, Give | No | 1 | ☐ Yes 2 💆 | | ano rican, etc.) | Speci | ack, White, ify: | WHITE |
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| | Anot | 4 VI | 1 (111 | 12. | | 9000 F | REISTERSTO | | EVINSON | | |
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| Sequential if ery, lead course. End of the course in the c | er aignificant control of the contro | Anter: Anter: Use Culd not be determined Pertifying Physical Examination of the culd not be determined. | d. d. http://discourse.com/d | Due to (of Due to | ER/Outpetient 28b. Time of Injury ome, farm, stre y) | uence of): uence ot): uence ot): uence of): uence | 26. Place of DOTHER: 26. Place of DOTHER: 4 Nursing Injury et Work? 1 Yes 2 No fice The time, date end place my opinion, death occurred to the place of the pla | 24e. We per 1 Check only 1 Home 5 Res 28d. Describe 28t. Location City or Touce, and due to the coursed at the time | s en eutopsy formed? Yes 2 No one) sidence 6 One how injury occu (Street end Num own, Stete) e ceuse(s) end no o, dete end place | ontribute t 3 Pro 24b. We expect of the contribute of the contri | No the cause of obably 4 Uvere autopsy tin veileble prior to ompletion of car of death? Uvere autopsy tin veileble prior to ompletion of car of death? Uvere autopsy tin veileble prior to ompletion of car of death? Uvere autopsy tin veileble prior to ompletion of car of death? Uvere autopsy tin veileble prior to ompletion of the death? Uvere autopsy tin veileble prior to ompletion of the death? Uvere autopsy tin veileble prior to ompletion of the death? Uvere autopsy tin veileble prior to ompletion of the death of |



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| | | | 4 2 | | Certificate of | Death | | Reg. No. | 1 | 3611 |
|---|--|--|--|---|---|---|----------------------------------|--------------------------------------|-------------------------|---|
| Physicia /Medic | - | Decedent's Name (First, Middle IRVIN | Last) | | SCHLOSE | ERG | 2. Date of Dea Month APRIL | 19, 199 | Year 9 | 3. Time of Death 9:00 PM |
| Examine | _ | 4a. Facility Name (If not institution | | 7) | | 4b. City, Town, or L | | , | | |
| Farmer | - | PIKESVILLE NUF 5. Social Security Number | | ge (In yrs. last bii | thday) If Under 1 Year | BALTIMOI If Under 24 Hrs. | 0 Date of Birth | BALTI | | |
| Funeral Director | | 231-05-4629 | 1 ⊠ M 2□ F | | Yrs. Months Days | | (Month, De) | , 1907 | Coun | elece (Stata or Foreign etry) MD |
| a-f show | ctor | 10a. State 10b. County | 'IMORE | 10c. City, Tow BALTIM | | | | | 1 | 0d. Inside City Limits 1 ☐ Yas 2 🛱 No |
| 23a or 28 ist be not | Funeral Director | 10e. Street and Number 7 SUDBROOK LAN | E | | 10f. Zip Code | 21208 | | 10g. Citizen of W | hat Cour | ntry? |
| 100 | Ď | 11. Marital Status 1 ☐ Navar Marriad 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced | 12. Was Deceden Armed Forces od 1 M-Yes 2 If Yes, Give Year or Dates | ? No | 13. Was Decadeni of If Yes, specify Cul | Becadeni of Hispanic Origin? (Specify Yass, specify Cuban, Mexican, Puerto Rican, West Specify: | | | k, White, | en Indian, etc. WHITE |
| dicel | Completed | 15. Decedent' (Specify only highes | | 16a | Decedent's Usual Occu (Give kind of work done | pation a during most of working | | 16b. Kind of Bu | siness/Inc | dustry |
| than " | dm | Elementary/Secondery (0-12) | Coilege (1-4or | | `life. DO NOT use retir WNER | ed) | | HOME R | EMOD | EI INC |
| Hygiana. ther thar ent, the | | 17. Fathar's Nama (First, Middle, L | ast) | | MIADIX | 18. Mother's Nam | e (First, Middle, | | | ELING |
| and Mantal F is marked of aumetic eve | To Be | JOSEPH | | SCHLOS | BERG | MARY | | | | IOWN) |
| alth and 27 is me er traum | | 19a, informant's Name/Relationsh WARREN SCHLOSE | | | . Mailing Address (Stree 904 ESGARTH | | | | Stete, Zip 211 | |
| nant of Health and: If Item 27 is ury or other tra | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | cemete | Disposition (Name of ry, cremetory or other plants TON CHTZUK | | Date /21/99 | 20c. Location - | | |
| Department of Important: If any injury or once. | | 21. Signature | censae | | 22. Name and Addr | ass of Facility | SOL LE | EVINSON | & BR | OS., INC. |
| 8 8 3 2 | | 1/1/2 | (| | 8900 REIS | TERSTOWN 1 | | | | |
| physicians the bur | an/Medical Examiner | shock, or heart failura. List of Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a | Due to (or as a | consequence of): | lead ing | dise | n e Se | | intarval Between Onset and Daeth |
| ed by the at datached fo | Physician/M | Part ii. Other significant condition | s contributing to death | but not resulting l | n tha underlying causa g | iven in Part i. | | . / | | the cause of death? |
| | by Pr | | | | | | 101 | Y 2 3 10 | 3 ☐ Prol | bably 4 🗌 Unknow |
| | Completed | | | | | | | an autopsy rmed? | av. | ere eutopsy findings aliable prior to mplation of cause death? |
| ata has paga 2 | E 0 | | | | | | 1 🗆 Y | as 2 No | 1[| Yes 200 |
| | Be | 25. Was cese referred to medicel examiner? | | | | 26. Place of Deal | h (Check only o | ne) | | |
| S D | 0 | 1 ☐ Yes 2 No | Hospital: | | Itpatient 3 DOA | | | ience 8 Othe | | y) |
| Olrector: Aftar | ion in | 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investig | 28a. Date of inj (Month, D | | | ork? ☐ Yes 2 ☐ No | 28d. Describe h | now injury occurr | ea | |
| d in by that | Certification: | 2 Accident Investig: 3 Suicide 6 Could not determine | ot be 28e. Place of in | nju ry - At home, fa tc. <i>(Specify)</i> | rm, street, factory, office | | 28f. Location (S City or Tow | Street end Numbern, Stete) | er or Rure | al Route Number, |
| | edical C | 29a. Certifier 1 Certifying (Check only one) 2 Medicai E | Phyaiclan: To the best kaminer: On the basis of and manner s | of examination an | o, death occurred at the t dor investigation, in my | ime, date and place, opinion, death occur | end due to the o | ceuse(s) end ma data and place, a | nner as s and due to | tated. o the ceuse(s) |
| To the Funeral completaly filled | 29b. Signature and title of certifier 29c. License number | | | | | | | 29d. Date signed | (Month, | Dey, Year) |
| | | 30. Name and address of person w | no completed ceuse of | deeth (item 23e) | (Type, Print) Gre | one Tre | e Rd | # 3 | 00 | Battollo |
| Stat | | 31. Date filed (Month, Day, Yeer) | 32. Regist | trer's Signeture | 4 loos | Kal | | | | 21208 |
| Registra | r - | | | | ALC: ALC: ALC: A | ALC: ALC: ALC: ALC: ALC: ALC: ALC: ALC: | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 35 April Day ANK /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Deaton Specialty Hospital and Home

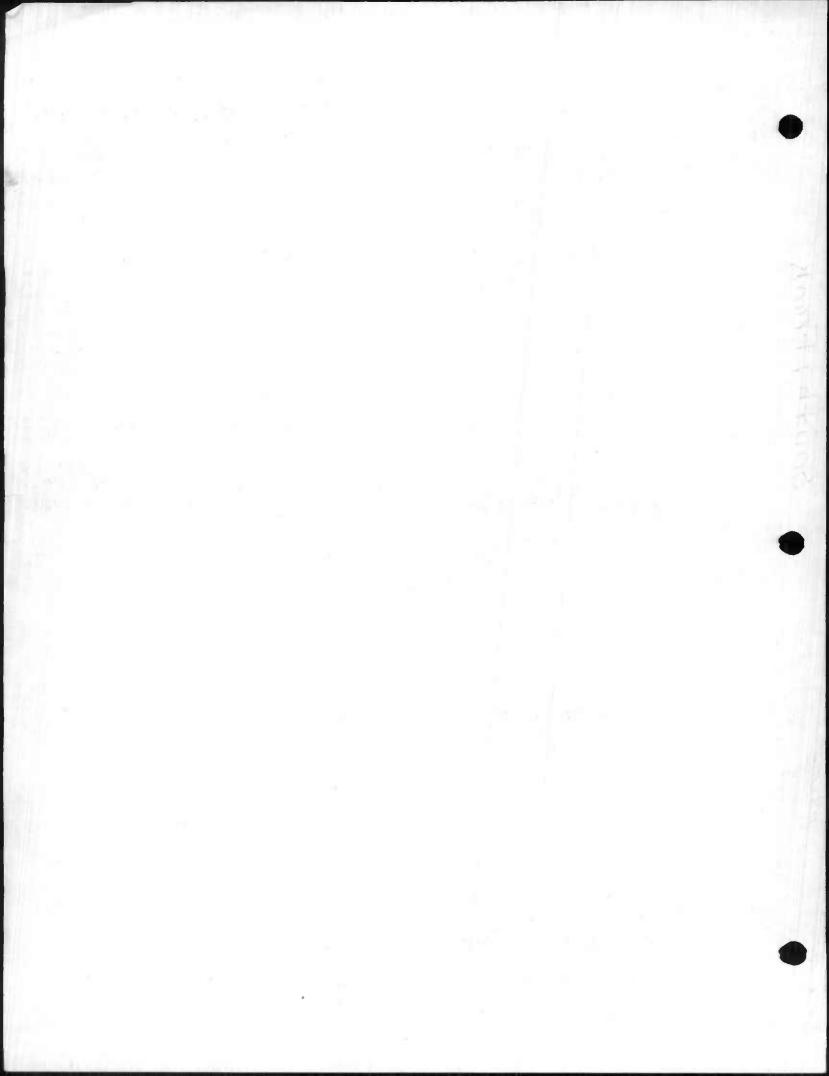
5. Social Security Number | 6. Sax | 7. Age (In yrs. last birthday) | If Under 1 Year | Months Days Baltimone 6. Sax 1 M 2 F If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer) Birthplaca (Stata or Foreign Country) **Funeral** 244-20-1599 Usual Residence of Decedent 77 Yrs. AUGUST 5, 1921 NORTH CAROLINA Director the Maryland 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 Yas 2 No BALTIMORE 101. Zip Coda Directo MARYLAND 10e. Street and Number 10a. Citizen of What Country? 611 SOUTH CHARLES STREET 21230 USA Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yas 200No Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) STADE Collega (1-4or 5+) MACHINIST MACHINE SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) PRINCE ANNA MILLER 19e. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (COUSIN) 2111 W. FAYETTE STREET BALTO, MD. 21223

20b. Place of Disposition (Name of cemefery, crematory or other place)

Date 20c. Location - City or Town, State LINVIL TURNER 20e. Method of Disposition

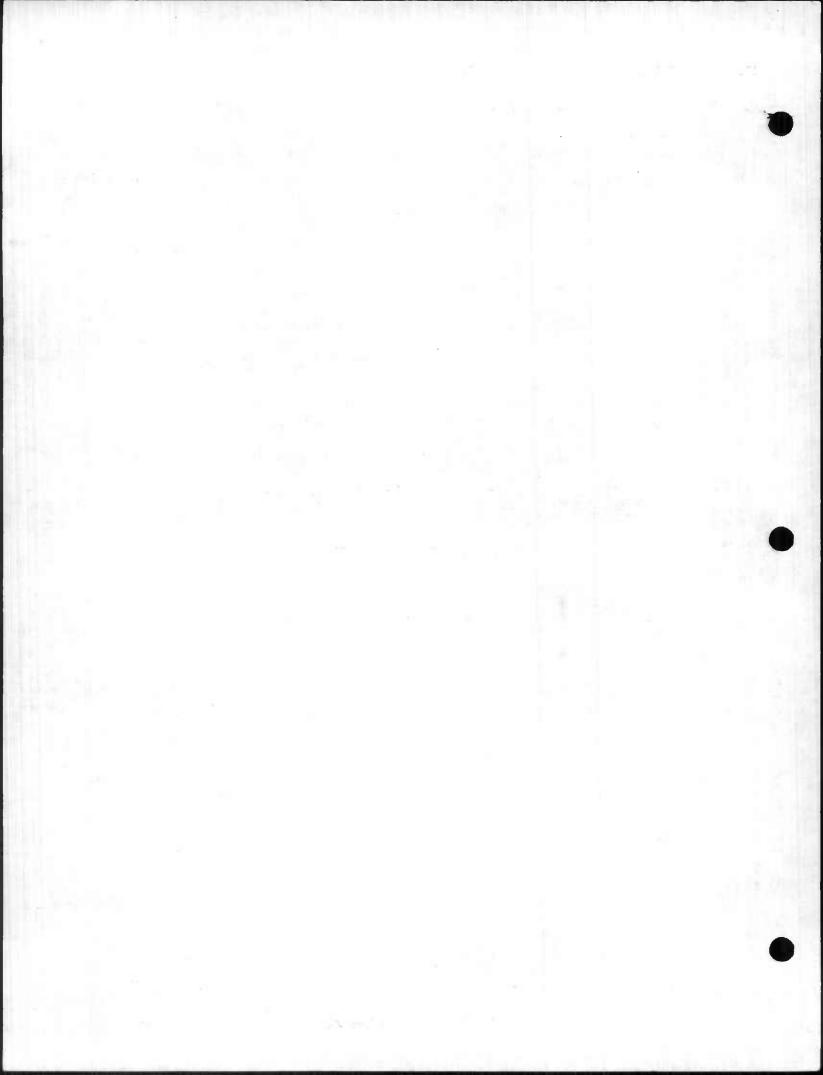
128 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 04-26-99 LANSDOWNE, MARYLAND 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, MD. 21217 21. Signature of Funaral Service Licanses 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory afrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Acidosis Memic Twk **Examiner** Due to (or as a consequence of): Examiner 3 wks allure physician end the buriel-trans Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the e should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atherosclerok. Vancular Records, þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital funeral director, 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of After 1 Natural 5 Pending Hospital or Attending
 24 hours efter death.
 Funeral Director: After 1 Yes 2 No investigation 2 Accident To the Hospital or Atter within 24 hours efter dec To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a Cartino Medical and title of certifier 296. 29c. Licansa number 29d. Date signad (Month, Day, Year) MD 038675 20199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MESHULAM JOEL 55 BALTIMORE MO 21230 HANOUER 5 1147 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 22 Registrar



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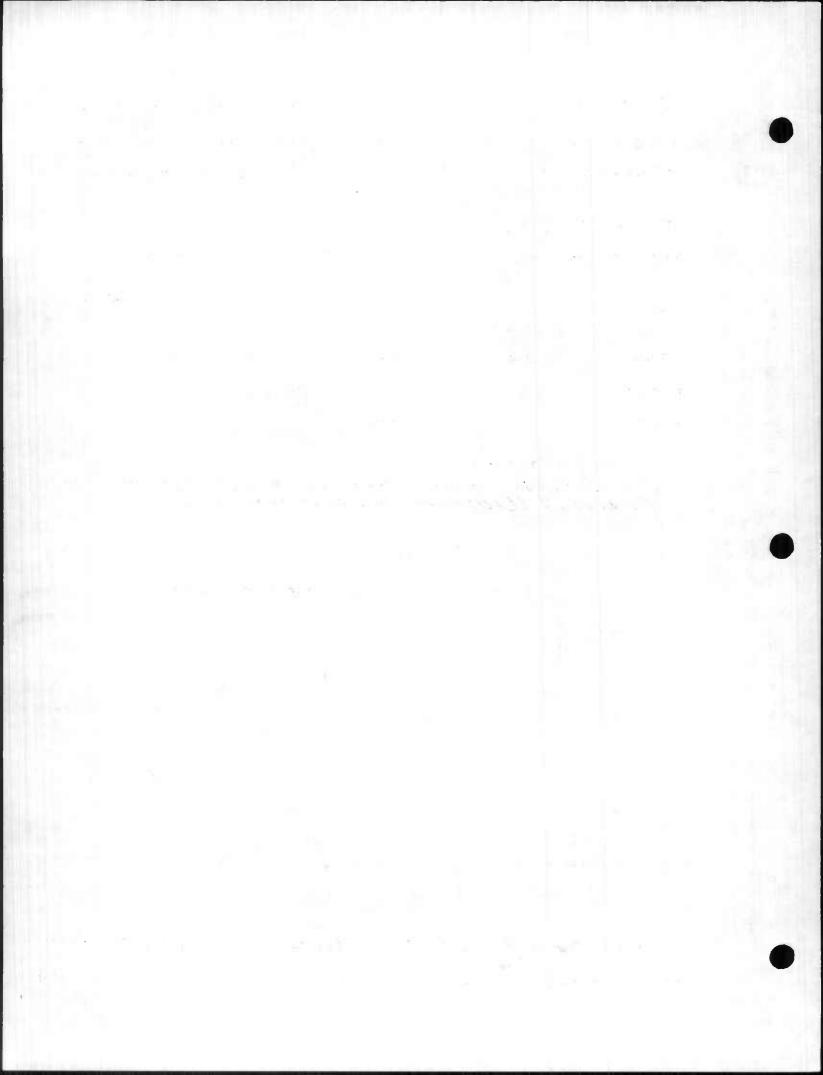
| ITEMS: 2 | 23 F | PART I, 27, PER MEO G77 | State of Maryla 1 5-12-99 WR. | | rtificate of | | | Reg. No. | | 3279 | | |
|--|----------------|---|--|-----------------------------|--|---|--|--|-------------|--|--|--|
| Physic | an | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of Dea Month | ath Day | Year | 3. Time of Death | | |
| 7Medi | | Steven Starkey | | | | | APRIL | 17, 199 | | 2031 PM | | |
| Examir | ner | 4a Facility Name (If not institution, give | | | | 4b. City, Town, or Lo | | 4c. County | of Death | | | |
| 14 | | JOHNS HOPKINS HOS 5. Social Security Number 6. Se | | rs. last birthday) | If Under 1 Year | BALITIMORE If Under 24 Hrs. | | N/ | | Inna (Chata as Cassian | | |
| Funeral Director | | | M 2□ F 47 | Yrs. | Months Days | Hours Min. | 8. Date of Birt (Month, Da Aug . 1 | y. Year) 8,1951 | | lace (State or Foreign try) Yland | | |
| Mend Mend | | 10a. Stele 10b. County | 10c. | City, Town or Lo | cation | | | | 1 | 0d. Inside City Limits | | |
| with the Marylen a or 28e-f ahow be notified at | to | Md. N/A | | Ba | ltimore | | | | | 1. Yes 2 No | | |
| the reserve | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of V | | ntry? | | |
| th will | alc | 17 North Glove | er Street | | 21 | 205 | | U.S.A. | | | | |
| 21215-0020 d within 72 hours after death with the Maryland glene. rr than "natural", or fierra 23a or 28e-f ahow in the Marcal Examiner must be incorrect at | by Funeral | 11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? 1√□Xes 2□No if Yes, Give Year or Detes: | | Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No | dispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | - 14, Race Blace Specify | k, White, | | | |
| 72 hours | Completed | 15. Decedent's Edu (Specify only highest grad | | 16a. Deced (Give | dent's Usual Occup | nation during most of work d) | ing | 16b. Kind of Bu | siness/Inc | dustry | | |
| 12 digit 7 | Idu | Elementary/Secondery (0-12) | College (1-4or 5+) | life. | DO NOT use retire | d) | | | | | | |
| DOL | | 12th 17. Father's Name (First, Middle, Last) | | Ca | rpenter | 18. Mother's Name | Firet Mirirllo | | | ovemen ts | | |
| aryland 212. should be filed within the Mental Hyglene. marked other than | Be C | Francis Sta | rkou | | | | | waroon our am | , | | | |
| Maryland d2 should be file th and Mental Hy 7 Is marked oth traumatic event | 7 | 19e. Informent's Name/Reletionship (7) | | 19b. Maili | na Address (Street | Ruth] | | er. City or Town, | State, Zio | Code) | | |
| .0 | | Francis J. Sta | | | | ns St.,E | | - 113-11-11-11-11-11-11-11-11-11-11-11-11- | | | | |
| Fe, M s 1 and 2 if Health Item 27 I | | 20a. Method of Disposition | 200 | b. Place of Dispo | | | Date | 20c. Location - | | | | |
| Baltimore, M permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Date. | | 1 Paurial 2 Cremetion 3 F 4 Donetion 5 Other (Specify) | | Oak La | wn Ceme | tery 4- | 23-99 | Balto. | , Md | • | | |
| Depart Person | | · Mittal | | Mo | oran-Asl | | | | | lome, Inc. . 21224 | | |
| | | 23e. Part1. Enter the diseese, or compleshock, or heert failure. List only or | ications that caused the d | | | | | | i | Approximate Interval Between | | |
| Physician | | ACCOUNT OF THE PARTY | | | | | | | i | Onset and Death | | |
| / /Medical Examiner | | fmmediete Cause (Final disease or condition resulting In deeth) | BRONCHOPNEUM | ONIA AND | DEHYDRATION | N . | | | 1 | | | |
| | 20 | in double) | Due to | o (or as a consec | quence of): | | | | 1 | | | |
| pet nsit | Examiner | | o | | | | | | i_ | | | |
| al-tre | xar | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due to (or es a consequence of): | | | | | | | | | |
| 68/60, ficate be executed physician and is the burial-trensit | dical | Cause (Disease or Injury that Initiated events | Dun to | | | | | | | | | |
| o phy as th | - 40 | resulting in deeth) Last Due to (or as e consequence of): | | | | | | | | | | |
| death certific | 2 | | 1 | | | | | | <u> </u> | | | |
| . 0 0 0 | sicie | Pert II. Other aignificant conditions cor | ntributing to death but not | resulting in the u | nderlying cause gi | ven in Part I. | 23b. Did | lobacco use cor | ntribute to | the cause of death? | | |
| · = 5° | Physician/M | | | | | | 10 | Yes 20 No | 3 Pro | bably 4 Unknown | | |
| es that igned to det | þ | | | | | | | | | | | |
| been s | Completed | | | | | | | an eutopsy med? | 80 | ere autopsy findings allable prior to impletion of cause death? | | |
| The lev | mo: | | | | | | 100 | res 2□No | 15 | Yes 2□ No | | |
| elclan: The certificate linector, pag | Be | 25. Wes case referred to medical examiner? | | | | 26. Place of Deat | h (Check only o | one) | 1 | | | |
| | 10 | Yes 2□ No | lospital: 1 Inpatient 2 | ER/Outpatier | nt 30XDOA Ot | her: 4 Nursing Ho | me 5 Resid | dence 6 Oth | er (Specif | (y) | | |
| E & 95 g | | 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Day Year | 28b. Time of Injury | Wo | ry at rk? j Yes 2 □ No | 28d. Describe I | how injury occur | red | | | |
| UNISION Hospital or Attending 24 hours after death. Funeral Director: After Naly filled in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - A building, etc. (Spe | t home, farm, str ecify) | eet, factory, office | | 28f. Location (: City or To | | er or Run | al Route Number, | | |
| UNISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the it. | Medical C | | sician: To the best of my liner: On the basis of examend manner stated. | | | | | | | | | |
| within 2 To the | Me | 29b. Signature and title of certifier | A | | 29c. Licens | se number | | 29d. Dete signe | d (Month, | Day, Year) | | |
| ->-0 | | Atroha 1 | Vac | 125 | 1/1 | OCME | Z | APRIL 18 | , 199 | 99 | | |
| | | 30. Name and address of person who co | empleted cause of death (f | teri 23a) (Type | Print) | | | | | | | |
| | | ^ | adentz, 11 | | | Baltimore | Marvla | and 2120 | 1 | | | |
| Sta | te | 31. Date filed (Month, Dey, Year) | 32. Registrar's Sig | gnature | | - Caron C | - LALLY AC | | - | | | |
| Registr | ar | APR 2 2 1999 | Brosser | fig. | how to | 6 | | | | | | |
| | | | 1 | - | Section 2 and a second | | | | | | | |



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| | 1. | Decedent's Name | e (First, Middle, L | ast) | | | | | | 2. Dete | of Death | | | 3. Tim | e of Death |
|---|--|---|--|--|--|--|--|--|--|---|---|--|--|--|--|
| ician dical | н | EDN | IIN | | | | TRA | 4V: | ERS | APP | EIL | Day | 1999 | 3:5 | 20 PM |
| ıcaı iner | 4a | Facility Name (II | f not institution, g | ive street and nun | nber) | | | | 4b. City, Town, | or Location of | Death | 4c. County | of Death | | |
| | | GOOD | SAW | MRITI | AN | 402 | 1 | 1 | 211- | IMOR | - | | Timo | RE | CITY |
| | | Social Security N 704-01-6 | 109 | Sex 10XIM 2□F | 7. Age (In yrs | | Month | ler 1 Year s Days | If Under 24 H | in. (Mon | of Birth th, Day, 1 | Year) 1915 | 9. Birthp Coun unkno | lace (State) Wn | te or Foreign |
| | | sual Residence of Da. State | Decedent 10b. County | | 10c. C | ity, Town or | Location | | | | | | 1 | Od. Insid | e City Limits |
| 0 | | **** | Baltin | mowo | | | | | | | | | | | res 2□ No |
| | 10 | laryland | | поге | D | altimo | | Zip Code | | | 100 | g. Citizen of V | Whet Coun | itry? | |
| | 5 | 601 Loch | Raven I | Rlvd. | | | | 21239 | | | 111 | nknown | | | |
| - | 111 | I. Marital Status | ied 2 Married | 12. Was Dece Armed For 1 Yes If Yes, Giv. | ces? unk: 2□No e | | 3. Was Dec | edent of F becify Cub | dispante Origin? an, Mexican, Pu Specify: | (Specify Yes erto Rican, et | | 14. Rac Blac | 14. Raca - American Indian, Black, White, etc. Specify: white | | ٦, |
| | - | 2K ANDOMAG | 15. Decedent's E | Year or Da | ites: | | inknov | Wn Isual Occupation | | | 11 | 6b. Kind of B | | | |
| | 1 | (Spec Elementery/Seconds (Special Control of Special ndary (0-12) | | -4or 5+) | (G life | ive kind of very not only not not not not not not not not not not | vork done | during most of | working | | nknown | | Judany | |
| 100000000000000000000000000000000000000 | 17 | 7. Father's Name (| | | | HITT | TOWIL | | 18. Mother's I | Name (First, A | | | ne) | | -124 |
| | u | ınknown | | | | | | | unknow | n | | | | | |
| 0 | | 9a. Informant's Na | ame/Relationship | (Type, Print) | | 19b. M | ailing Addre | ss (Street | and Number or | Rural Route | Vum <i>ber</i> , | City or Town, | State, Zip | Code) | |
| | u | ınknown | | | | | nown | | | | | | | | |
| | 20 | Da. Method of Disp 1 ☐ Burial 2 [4 ☐ Donation | Cremation 3 | □Removal from S | State | Placa of Di cemetery, o | sposition (A crematory of | leme of r other pla | ce) | Date | 20 | Oc. Location - | - City or To | wn, Stat | Э |
| Tedical Examiner | | | | | | | | | ng, such as card | | | | | Onset a | Between nd Death |
| | SH CC th | mmediate Cause (isease or condition soutting in deeth) fequentially list con any, leading to im ause. Enter Unde ause (Disease or nat initiated events esulting in death) L | nditions, imediate rhying Injury | a | Due to | Cum (or es e con (or as a con | onía sequence o wctiv sequence o | n): Le P | oulmon | | A. | ease | | Interval Onset a | Between and Death |
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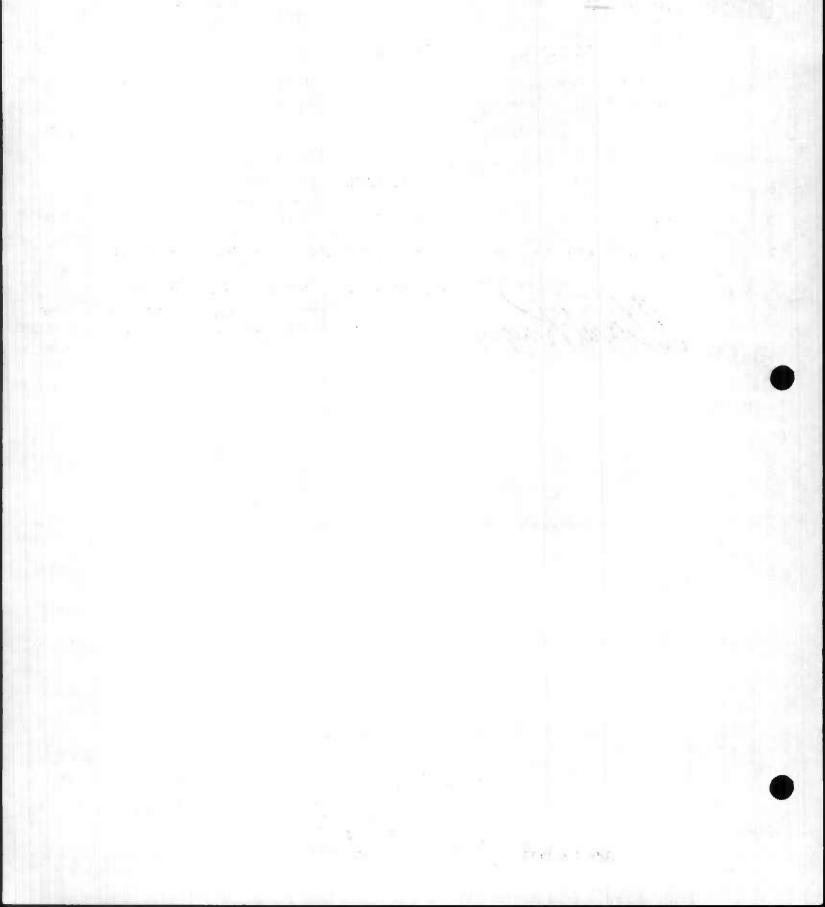
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State of Maryland / Department of Health and Mental Hygiene 0

| Physician | 5 perFHG770 4/22/99 1. Decedent's Neme (First, Middle | le, Last) | | | | 2. Dete of Death | J. No. | Vaca | 3. Time of Deeth | 1 |
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| /Medical | SELMA | н. | | TAYLOR | | APRIL 1 | 9 ^{, Dey} 1999 | Year | 12:05 PM | ı |
| Examiner | 4a Facility Nema (If not institution | | | | 4b. City, Town, or Lo | cation of Death | 4c. County of | | | 1 |
| | HOSPICE OF BAI | | | | TOWSON | | | | IMORE | I |
| uneral Pirector | 5. Sociel Security Number 146-18-1922 Usuef Residence of Decadent | 6. Sex 1 M 2 | e (In yrs. last bir 76 | Yrs. If Under 1 Year Months Deys | | 8. Dete of Birth (Month, Day, 1) OCT 22 | (ear) , 1922 | 9. Birthple Count | ece (Stata or Foreign ny) NY | |
| ž u | 10e. State 10b. County | | 10c. City, Tow | n or Location | | | | 10 | d. Inside City Limits | 1 |
| to to | MD BALT | TIMORE | BALTI | MORE | | | | | 1 ☐ Yes 2 No | I |
| a or 28a-f s it be notified if Director | 10e. Street and Number 9 REGENCY COUR | RT | | 10f. Zip Code | 21208 | 10 | g. Citizen of W | het Count U.S. | - | - |
| r hems 23a oliner munt Funeral | 11. Marital Status | 12. Wes Decedent I | Evar in U,S. | 13. Was Decedent of | Hispanic Origin? (Spe ban, Mexican, Puerto | cify Yas or No- | | - Amarica | | |
| by By | 1 ☐ Never Married 2 ☐ Man 3 ☐ Widowed 4 ☐ Divorced | ried 1 ☐ Yes 2 📉 N | 40 | 1 ☐ Yes 2 No | | rioan, ato., | Specify: | c, White, e | WHITE | |
| nt, the Madical Completed | 15. Deceden | it's Education st grede completed) | 16e. | Decedent's Usuel Occu (Give kind of work done | a during most of worki | na 1 | 6b. Kind of Bus | siness/Ind | ustry | |
| M QH | Elementary/Secondery (0-12) | College (1-4or 5 | +) HC | life. DO NOT use retire MEMAKER | ed) | | NOH NWC | Æ: | | I |
| event, the | 17. Fether's Neme (First, Middle, | Last) | 110 | N. HELLENKER | 18. Mother's Neme | | | | | - |
| | SAMUEL | , | WEIDE | ENFELD | SARAH | , | | -, | LEVIN | I |
| raumatic To | 19e. Informent's Neme/Reletions | ship (Type, Print) | | . Meiling Address (Stree | | I Route Number, | City or Town, S | Stete, Zip | | 1 |
| | DR. RONALD TAY | YLOR / SON | 11 | REGENCY CO | OURT - BAL | TIMORE, | MD 212 | 809 | | |
| nt: If item 27 ry or other ti | 20e. Method of Disposition 1 🖾 Buriel 2 ☐ Cremation 4 ☐ Dopation 🔏 ☐ Other (S | | cemete | f Disposition (Name of ry, crematory or other plants NGTON CHIZUE | | | 0c. Location - 0 | | | |
| Important: hand injury o | 21. Significe of Funeral Service | | | 22. Neme end Addi | ress of Fecility | SOL LEV | TNSON 8 | BRO | S., INC. | |
| E 2 8 | MIMON | Kruper | | 8900 RE | ISTERSTOWN | | | | | |
| | 23 Part. Enter the disease or shock, or heart failure. List | complication, thet caused only one cause on each lin | the deeth. Do | not enter the mode of dy | ring, such es cardiec d | or respiretory erres | st, | | Approximate Intervei Between | 1 |
| ysician | | 1 | | | | | | 1 | Onset and Deeth | ĺ |
| ledical aminer | immediate Cause (Finel disease or condition resulting in death) | a. L. | ng | CANC | er | | | 1 | 12 month | |
| a | | | Due to (or as e | consequence of): | | | | 1 | | ı |
| siclan end burial-transit | Convention that the distance distance | b | Due to /or es e | consequenca of): | | | | - 1 | | Į |
| Exa | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disesse or Injury that initiated events | | D00 10 (01 03 a 1 | consequenca ory. | | | | | | I |
| s the bur | Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest | C | Due to (or es e | consequence of): | | | | - | | |
| | Tooling it doolly Look | d | | | | | | 1 | | |
| d by the attending etached for usa and Physician/M | Pert II. Other significant condition | and contribution to double by | st not consider a | the underlying equal | ivan la Dart I | 23h Did toh | | telbute to | the cause of death? | |
| by the | reit ii. Other significant condition | ons contributing to death bu | at not resulting ii | i the underlying cause g | Well in Pert I. | 1 Yes | 2.1 | 3 □ Prob | | I |
| be det | | | | | | | 7 | | | |
| S D | | | | | | 24a. Wes en perform | eutopsy ed? | ava | re eutopsy findings iilabla prior to | I |
| 6 9 e | | | | | | | | of c | nplation of causa leeth? | |
| 2 should | | | | | | | | 4.0 | IV. O No | |
| te has page 2 | | | | | | 1 □ Yes | 2 No | 1 | Yes 2□ No | 4 |
| omp | 25. Wes case referred to medica examiner? | | | 1 = | 26. Place of Deeth | | | | JYes 2LINO | |
| his certific Il director, To Be | examiner? 1 ☐ Yes 2 No | Hospitel: 1 Inpatia | | Itpatient 3L DOA | ther: 4 Nursing Ho | n (Check only one me 5 ☐ Rasider | nca 6 Otha | ar (Specify | 1/ 450 | |
| his certificate has al director, page 2 To Be Comp | examiner? 1 Ves 2 No 27. Menner of Deeth 1 Naturel 5 Pendir | Hospitel: 1 Inpatia 28e. Date of Injur (Month, De) | | Time of 28c. Injury | ther: 4 Nursing Houry et ork? | (Check only one | nca 6 Otha | ar (Specify | 1/ 450 | |
| nis certificate has il director, page 2 To Be Comp | examiner? 1 Yes 2 No 27. Megner of Deeth 1 Naturel 5 Pendir 2 Accident Investi 3 Suicide 6 Could | Hospitel: 1 Inpatia 28e. Date of Injur (Month, Deg gation not be inped 28e. Pleca of Injur 28e. Pleca of Injur | Year) 28b. 1 | Time of 28c. Injury | ther: 4 Nursing Hoursing Hours et ork? | me 5 Rasider 28d. Describe hov | oca 6 Otha v injury occurre | ar <i>(Specify</i> ed | Hospice | |
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| rector. After this certificate has not the funeral director, page 2 rtification: To Be Comp | examiner? Yes No | Hospitel: 1 Inpatia 28e. Date of Injur (Month, De) gation not be 28e. Pleca of fnju building, etc g Physicfen: To the best of end menner ste who completed cause of Me e y Carm | y Year) 28b. f | ime of njury M 15 28c. Injury M 15 28c. | ther: 4 Nursing Houry et ork? Yes 2 No time, dete end plece, opinion, deeth occurr | me 5 Rasider 28d. Describe how 28f. Location (Strr. City or Town, end due to the cat ed at the time, de | oca 6 Otha vinjury occurre seet and Number Stete) | or (Specify and Specify and Sp | Poute Number, eted. the cause(s) | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's)Name (First, Middle, Last) '80cm Physician /Medical 4b. City, Town, or Location of Death, 4c. County of Death 4a Facility Name (If not institution Examiner altimore Takyland If Undar 24 Hrs. 8. Data of Birth (Month, Pey, 5. Social Security Number 238-20-859 Usual Residence of Decedent If Under 1 Year Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. lest birthdey) **Funeral** Days 10 M 20 F **Director** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits itsm 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Madical Examiner must be notified at 1 Yes 2 No Director 10e. Streel and Number 10f. Zip Code 10g. Citizen of Whel Country? Funeral 13. Was Decedent of Hispanic Origin? (\$ If Yas, specify Cyban, Mexican, Puerto Was Decedent Ever in U,S Armed Forces? 14 Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1□Yes 2☑No Specify þ 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) linge Link unce is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) and Mental und 2 19a. Informani's Name/Relationship (Type, Print) Guardin 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bulto, MO 2/20/ ate 20c. Location - City or Town, State Department of Health important: If Itam 27 altimore, 20b. Place of Disposition (Neme of cematary, cremetory or other place) 20a. Mathod of Disposition 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State any injury or 4/22/99 Cumdowne, MD 21100 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License FUNDEAR HOME, P.A. 23a. Part 1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only do cause on each line. PNO 21217 BALTIMORE Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Due to (or es a consequence of): Examiner DOW Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury Ihal Initiated avents resulting In deeth) Last Due to (or as a consequence of): and requires that the death certificate be exec Box 68760 attending physician Physician/Medical es the Dua fo (or as a consequence of): USB 23b. Did tobacco usa contributa to the cause of deeth? P.0 Part II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown 6 Division of Vital Records. by 8 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed need completion of ceuse of death? cartificate has 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cesa referred to medicel axaminer? 1 ☐ Yes 2 ☐ No Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) uneral 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After t 1 DNatural 5 Pending Investigation death. 2 No 1 ☐ Yes 2 Accident after death 28f. Location (Street end Number or Rural Route Number, City or Town, Stefa) 6 Could not be determined 3 ☐ Suicida 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide Hospital c 24 hours al Funerel D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated. (Check only one) To the P 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year)

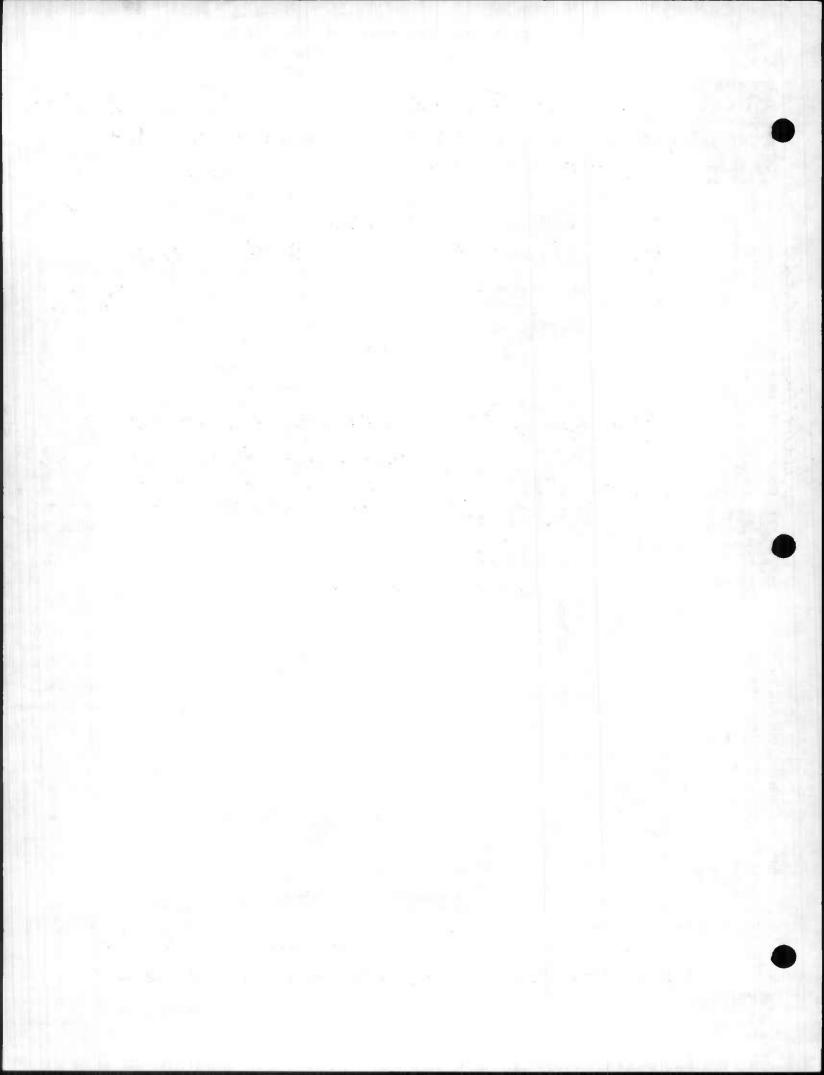
State Registrar 31. Date filed (Month, Day, Year)

APR 2 2 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) marad,



m.D.Co



Please Type or Print In Black Indelible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Year 1999 TRACEY 6:20 AM VIRGINIA APRIL 17 ONEDA 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth BALTIMORE If Undar 24 Hrs. 8. Date CENTER GREATER BALTIMORE MEDICAL BALTIMORE If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 10M 20F Months Days Hours Min Yrs. 214-26-89 45 MARCH 27,1914 MD Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE / TOWSON BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number U.S.A BAVEN 21239 BLUD. # 230 6401 LOCH 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced WHITE 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AT HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN GRADY LANDORA POMERDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 KNOLL CREST PLACE #J COCKETSVILLE, MD. 21030 BARBARA BARTLETT, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State APRIL, 20 4 ☐ Donation 5 ☐ Other (Specify) PINE GROVE CEMETERY PARKTON 1999 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Furieral Service Licensee 8800 HARFORD RD. PARKVILLE, MO. 212 23a. Part1. Enter the disease, or completions that caused in shock, or haart failure. List only one (aluse on each line Approximate Interval Between Onsat and Death adopts that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disaase or condition resulting in death) na Due to (or as a consequence of a Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 20 No 2 NO NO 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Physician /Medical Examiner

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physician ar

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After

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• Funeral Director: After death, diesely filled in by the fun

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Certification:

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The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Physician:

or Attending

Physician

/Medical

Examiner

Funeral

Director

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7 is merised other than "natural", or items 23s or traumstic event, the Medical Exerciner must be o

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should be filed within Hygiene.

h and Mental 7 is marked of

permit. Pages 1 and 2 st Department of Health an Important: If New 27 is n

b

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case reterred to medical examiner? 1 Yes 2 No Inpatiant 2 ER/Outpetient 3 DOA 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending 1 Netural

investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 4 ☐ Homleide

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

w

29d. Data signed (Month, Day, Year) 19,1999 APRIL

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

6800 VHOL. 90 RD. BOWIE YDRK

31. Date filed (Month, Day, Year) APR 2 2 1999

STE. B BAIDMORE, MD. 21212 32. Registrar's Signetur

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DHMH 16 Rev 6/95

State

Registrar

along the conjugation of a first or the own one and

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death Dey Month Yee ROSE MEIERO WITZ 7:45 AM APRIL 19 99 4a Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER | H Under 1 Year | H Under 24 Hrs. | 8. Deta of Birth (Month, Dey, Year) | AUG 16,1915 Birthplece (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 🗙 F 214-22-2274 83 Yrs. NY Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6982 MILBROOK PARK DRIVE 21215 #1-D U.S.A. 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Dates: Wes Dacedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 □ Navar Married 2 □ Married 1 Yes 2 XNo Specify: WHITE Specify: 30K Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERK LIQUOR STORE 18. Mother's Neme (First, Middle, Meiden Sumema) 17. Fethar's Name (First, Middle, Last) WOLFE BENZION CLARA FLASHNER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) SHIRLEY KLUPT / DAUGHTER 212 CHERRY VALLEY ROAD - REISTERSTOWN, MD 21136 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) MIKRO KODESH BETH ISRAEL 4/21/99 BALTIMORE, MD 21. Signature of Finerel Service Licensee 22 Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel SEPSIS disaese or condition resulting in death) Due to (or as e consequence of): 6 CONGESTIVE CARDIOMYOPATH Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings avellable prior to complation of ceusa of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 No. 25. Wes cese referred to medicel examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No

Physician /Medical Examiner

ician and buriel-trans

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Affer

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To the Within 2

Hospital 24 hours

physician

Examiner

Physician/Medicai

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Physician

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MD

Director

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7 is marked other than "naturel", or items 23a or 28a-f ahow traumatic avent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelih and Mentel Hyglene. Important: If item 27 is marked other than "naturel", or item any Injury or other traumatic.

Maryland 21215-0020

Baltimore.

Box 68760-

Division of Vital

Sequentielly list conditions, if any, laeding to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieled events resulting in deeth) Lest

DIABETES

RENAL INSUFFICIENCY

Hospitel: 1万 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28b. Time of 28d. Describe how Injury occurred

27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, Ierm, street, fectory, office building, etc. (Specify)

29e. Certifier

15 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Deta signed (Month, Dey, Year)

29b. Signeture and title of certifier K. S. RAO. M.D

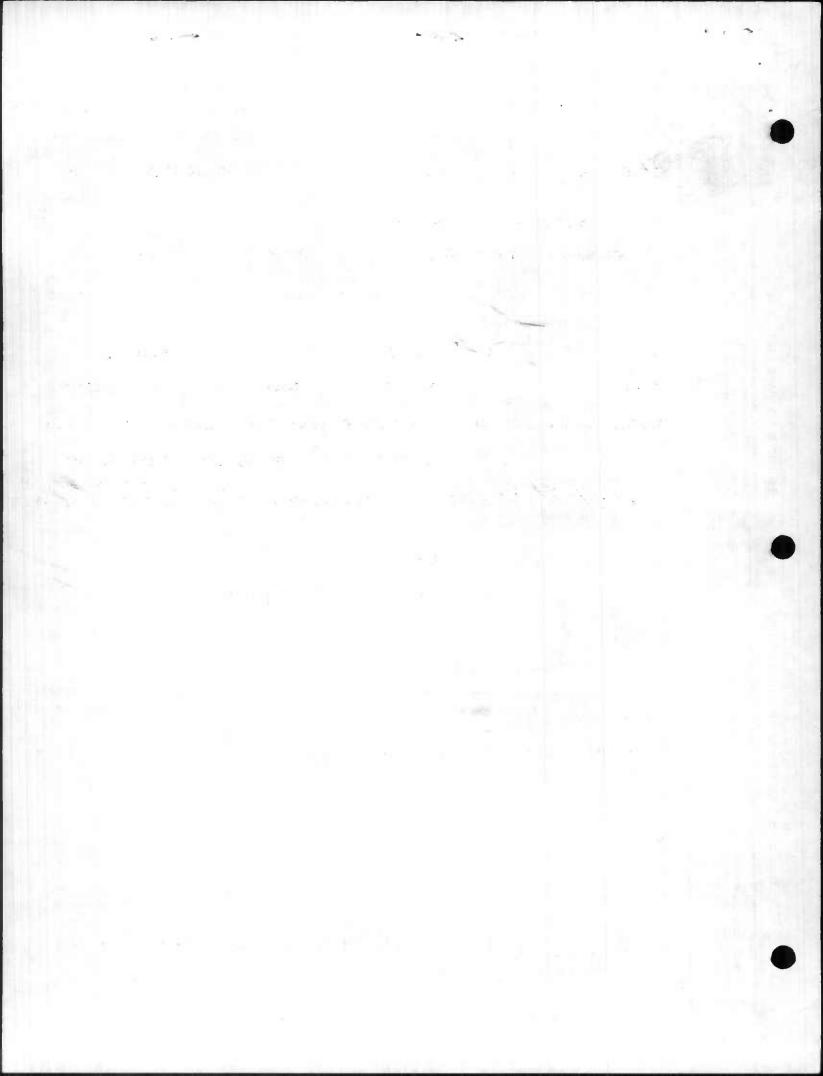
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APRIL 19,

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1 . 3 . R A o . 17 . D .

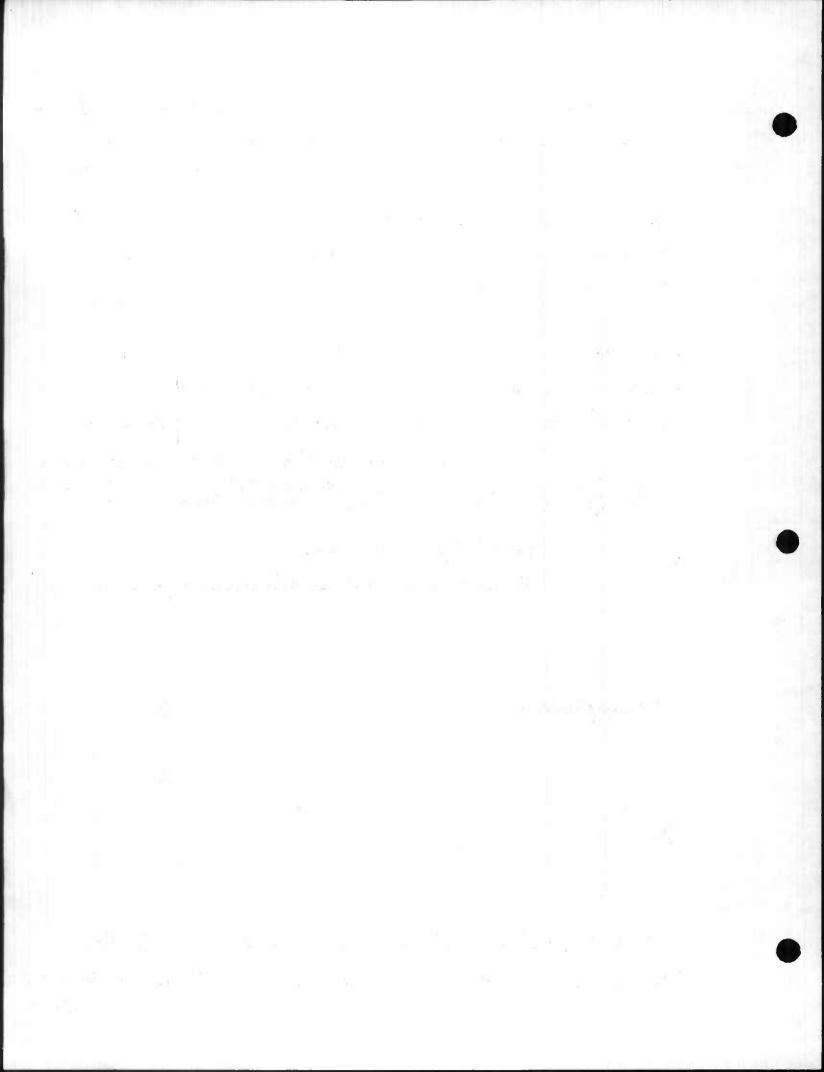
RANDALLSTOWN NORTHWEST .. HOSPITAL CENTER 31. Dete filed (Month, Dey, Year) APR 2 2 1999 32. Registrer's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

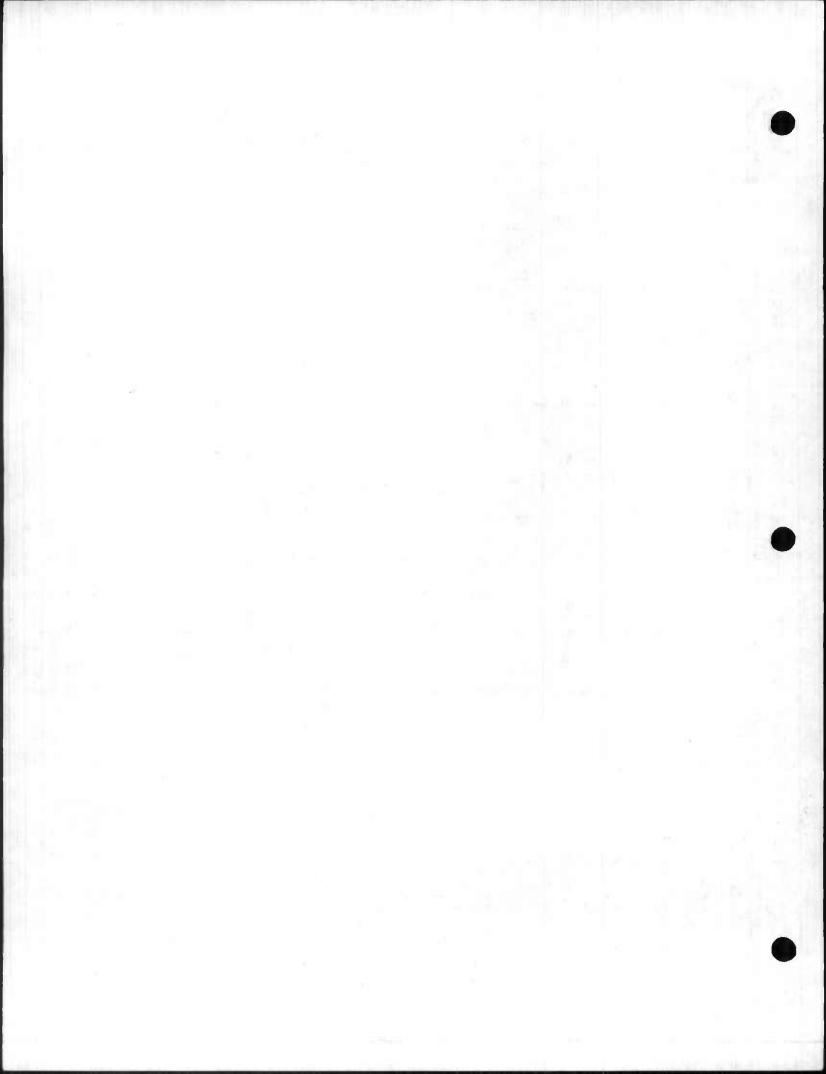
| | | | | | Certifica | ate of | Death | | Reg. No. | 7 1 | 1260 |
|---|----------------|---|--|----------------------|------------------------------|-------------------------|---|---------------------------------|---------------------|--------------|--|
| Dhualala | | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Dete of De Month | eth | Vane | 3. Time of Deeth |
| Physicia /Medic | | GIREGORY ALLEN | WILSON | | | | | 04-1 | 17- 99 | Year | 925 pm |
| Examin | | 4e. Fecility Neme (If not institution, give | street end number) | | | | 4b. City, Town, or | Location of Deeti | 4c. Count | y of Deeth | |
| | | DEATION NURSING | 3 HOME | | | | BALTIMOR | 2E | | NA | |
| Funeral | | 5. Sociel Security Number 6. Sex | 7. Age (| In yrs. lest birth | day) If Unday) Month | der 1 Year | If Under 24 Hrs Hours Min. | 8. Dete of Bir (Month, Da | th Veer | 7 | plece (State or Foreign |
| one. than "naturel", or items 23a or 28a-f show for Madical Examinar must be notified at | | 218-18-3883 Usual Residence of Decedent | [™] 2□ F 3 | 7 Y | rs. | | 7,00,0 | 08-20 | 1-61 | Oodi | mo mo |
| how | | 10a. Stete 10b. County | | Oc. City, Town | | | | | | 1 | 10d. Inside City Limits |
| 28a-f show | cto | MD N | A | BALTIM | DRE | | | | | | 1 ØYes 2 □ No |
| or 28 | Director | 10e. Street end Number | | | | Zip Code | | | 10g. Citizen of | Whet Cour | ntry? |
| 23a or | la | 4634 KOKEBY KO | AD | | | 2177 | 9 | | - 1 | ISA | |
| items rear m | Funeral | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | er in U,S. | 13. Was De | cedent of h | lispenic Origin? (S an, Mexicen, Puerl | pecify Yes or No | - 14. Ra | ce - Americ | |
| 8 | by | 1 ✓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: | | | 2 No | Specify: | o 1 110a11, 010.7 | Specia | _ | ACK |
| ical | Completed | 15. Decedent's Edu | | 16e. [| Decedent's U | sual Occup | pation | | 16b. Kind of B | lusiness/in | |
| Med a | ple | (Specify only highest grede Elementery/Secondary (0-12) | College (1-4or 5+) | | Give kind of life. DO NOT | work done use retige | during most of word) | rking | | 1 | |
| Mentel Hygiene. arked other than atic event, me | Оп | 8 TH GRADE | NA | | | NA | F | | | NA | |
| Health and Mantel Hygiene. Item 27 is marked other than "naturel", other traumatic event, in a Madical Exis | Be | 17. Fether's Name (First, Middle, Last) | , | | | | 18. Mother's Nar | ne (First, Middle, | Maiden Sumer | ne) | |
| rked | To | GEORGE LEE WIL | SON | | | | MARIAN | J MII | 19 | | |
| is me | | 19e. Informent's Name/Reletionship (Ty) | oe, Print) | 19b. | Malting Addre | ess (Street | end Number or Ru | | er, City or Town | Stete, Zip | Code) |
| em 27 i | | MARIAN WILSON | | 4/2 | 34 K | OKEB | V RD. | BALTO | mp. | 212 | 299 |
| | | 20e. Method of Disposition | | 20b. Plece of I | | Verne of | 4 | Dete | 20c. Location | - City or To | own, Stete |
| 7. F. F. | | 1 Ø Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emovel from State | KILK | MEM | ממיני) ו | Page 1 | 1-22-00 | Pariodi | 10701 | UKI MD |
| Important: If any injury or ance. | | 21. Signeture of Funeral Service License | 100 | IINO | 22. Name | end Addre | ss of Fecility | | KANDAL | | |
| Departm Importal eny inju | | 12 | / h | | 5151 | BALTO |). NATL | PIKE, R | BALTO. 1 | no. 2 | 1229 |
| | | 230 Port Falor Walls of Complete | | lu | VAUGI | TV (| C. GREE | NE FU | NERAL | SE | |
| | | 23e. Pert1. Enter the diffusese, or complishock, or heer thingre. List only on | e ceuse on eech line. | o death. Do no | n enter the m | lode or dyn | ng, such es cardiac | or respiretory e | rrest, | 1 | Approximete tntervel Between Onset end Death |
| ysiclan Jedical | | tmmediete Ceuse (Finet | iNlasti | 20 5 | | 00.0 | 0 | | | | Onest and Death |
| aminer | | disease or condition resulting in death) | VVasti | 19 -4 | rian | orn | | | | | |
| | - e | | 1 can | e to (or es e co | nsequence | of): | 10. | | | | |
| _ usit | Examiner | _ b | Washi | reacs | 4rirn | VA | o overic | iency | 34/10 | croi | ne |
| hysician end the buriel-trensit | Xa | Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury | Du | e to (or es e co | nsequence o | of): | | , | • | | |
| | | Cause (Diseese or injury that initiated events | | | | | | | | | |
| phys the | edical | resulting in deeth) Lest | Du | e to (or es e co | nsequence o | f): | | | | į | |
| e iii | Σ. | | | | | | | | | | |
| for u | Slar | | | | | | | | | | |
| ed by the deteched | Physician | Pert II. Other significent conditions con | | ot resulting In | he underlying | g ceuse giv | ven in Pert I. | 23b. Did | tobacco use co | ntribute to | o the cause of death |
| ed by | | 3chizophrer | 112 | | | | | 1 🗆 | Yee 2 No | 3 Pro | bably 4 Unknow |
| P e | l by | | | | | - | | | | T | |
| houl | Completed | | | | | | | 24e. Wes perfo | en eutopsy rmed? | ev | ere eutopsy findings eiteble prior to impletion of ceuse |
| has b | 힐 | | | | | | · · · · · · · · · · · · · · · · · · · | | | of | deeth? |
| pege | ခြေ | | | | | | | 101 | Yes 2 No | 1[| ☐ Yes 2☐ No |
| 100 | Be | 25. Wes cese referred to medical exeminer? | | | | | 26. Place of Dec | oth (Check only o | nne) | 1 | |
| 0 0 | 2 | 1 ☐ Yes 2 No | ospital: 1 Inpatient | 2 ER/Outp | etient 3 | DOA Oth | ner: 4 Nursing H | lome 5 Resid | dence 6 Ott | ner (Specif | (y) |
| neral | | 27. Manner of Deeth 1 Naturel 5 □ Pending | 28a. Dete of tnjury (Month, Dey Yo | 28b. Tir | me of ury | 28c. Injui Wo | | | now injury occur | | |
| d in by the funera | atic | 2 Accident Investigation | (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | M | | Yes 2 □ No | | | | |
| by ti | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Plece of Injury building, etc. (3 | - At home, fern | n, street, fect | ory, office | | 28f. Location (S City or Tox | Street end Num | ber or Rura | al Route Number, |
| od in by | Se | | building, etc. (| apacity) | | | | City of Tor | vii, Stete) | | |
| ly fill | | 29a. Certifier Certifying Phys | Iclen: To the best of m | y knowledge, | deeth occurre | ed et the tir | ne, date end plece | , end due to the | ceuse(s) end m | enner es s | teted. |
| Plete | edical | one) 2 Medical Examin | er: On the basis of ex end menner stated | aminetion end/ I. | or investigeti | on, in my o | pinion, deeth occu | rred et the time, | dete end plece, | end due to | the ceuse(s) |
| To the Funerel Di completely filled in | ž | 29b. Signeture end title of certifier | | | 2 | 9c. Licens | se number | | 29d. Dete signe | d (Month, | Dey, Year) |
| - | | Carla (| ileya | nder | D | Di | 8045 | 7 | 41 | ZZ | 99 |
| | 1 | 30. Name and address of person who con | moleted cause of doct | h (Itam 22a) /T | VDe Print\ | | | | 1] | 021 | • / |
| | | A | EXAND | | 10^{2} | 295 | 00000 | O CL | Cr.11- 2 | m | Bast, ma |
| -0. | | 31. Dete filed (Month, Day, Year) | 32. Registrer's | | 10 6 | -12 | yreer | E DT. 6 | swife - | w, 1 | DUM, ITTO |
| Stat Registra | | BDD 9 4000 | Sz. Hagistiel's | Jana La | 1 | | , | | | | 2120 |



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| | | State | of Marylar | | artment of tificate o | Health and f Death | Mental Hy | rgiene 9 | 9 | 3286 | |
|--|---|--------------------|---|------------------------|---|---|------------------------|---------------------------------|---|--|--|
| Physician | Decedent's Neme (First, Middle SUSAN | | WRIGHT | | | | 2. Dete of De Month | eath Dey | Year 999 | 3. Tima of Death 40;59 AM | |
| /Medical Examiner | 4a Fecility Neme (If not institution, UNION MEMORIA) | give street and n | | | | 4b. City, Town, or BALTIMO | Location of Dea | th 4c. County | of Deeth N/A | | |
| Funeral Director | 5. Social Security Number 249-66-3023 | 6. Sex | 7. Age (In yrs. 57 | last birthday) Yrs. | Months Dey | | | ay, Year) | | ace (State or Foreign ry) H_CAROLINA | |
| 9 2 | Usual Residence of Decedent 10a. State 10b. County | | 10c Ci | ty, Town or Lo | cation | | | | | od. Inside City Limits | |
| death with the Maryland ma 23s or 28s-f show mast be notified at neral Director | MARYLAND N/ | Δ | 100.01 | | LTIMORE | | | | | 1√2 Yes 2 No | |
| vith the Mai | 10e. Sfreet and Number | | | Des | 10f. Zip Code | | | 10g. Citizen of V | Vhat Count | ry? | |
| h with | 1623 N. BRADFO | RD | | | 21 | 213 | | U.S | .A. | | |
| E 2 2 5 | 11. Meritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | Armed F | 2 No Sive No | | Was Decedent of Yes, specify Co | Decedent of Hispanic Origin? (Specify Yes or No., specify Cuben, Mexican, Puerto Rican, etc.) Specify: | | | No- 14. Race - American Indien, Bleck, White, etc. Specify: AFRO-AMERICA | | |
| 5-0 72 ho natur solcal | 15. Decedent (Specify only highest | t grade completed | | (Give | lent's Usual Occ kind of work dor OO NOT use reti | e during most of w | orking | 16b. Kind of Bu | usiness/Ind | ustry | |
| d 2121 filed within Hyglene. ther than and, the Me | Elementery/Secondery (0-12) | Cotlege N/A | (1-4or 5+) | MEDI | CAL FIL | LER | | MICRO- | BTOTO | GY CO. | |
| Maryland 21215-0020 d.2 should be filed within 72 hours aft in and Mental Hyghene. The marked other trains natural, or traumatic event, the Medical Estimation To Be Completed by F | 17. Fether's Neme (First, Middle, L NATHAN NOLE | | | 111101 | | | | , Maiden Suman | | | |
| ary shou and M | 19e. informent's Neme/Retetionsh | ip (Type, Print) | | 19b. Meilin | ng Address (Stre | et and Number or F | Rural Route Numi | per, City or Town, | State, Zip | Code) | |
| and 2 | MICHELE BENSCH | / DAUGH | TER | 15213 | hanove | r pike up | perco, r | nd. 2115 | 5 | | |
| Baltimore, Maryland 212' permit. Pages 1 and 2 should be flied within Department of Health and Mental Hyglene. Important: if Nem 27 is marked other than any Injury or other tranmatic event, the Mental Page 1 is a present of the Compile of the Com | 20a. Method of Disposition 1. Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp | | n Stete | cemetery, cren | sition (Name of natory or other p ALLEY M | AEM. GARDE | | 20c. Location - 999 BALT | City or Tov | | |
| Balti permit. Departi Importa any lole | 21. Signature of Funerel Service 1 | icensee | nan d | 22 | . Name end Add | | | L HOME | | 12.50 | |
| | 23a. Pert1. Enter the disease, or shock, or heart feilure. List of | complications thet | caused the deel | th. Do not ente | 412 E | PRESTON S ying, such es cardi | TREET I | BALTO, M | D. 2 | 1213 Approximate | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | cute r | | dial Tr | farction | | | 1 | Interval Between Onset and Deeth 1/2 DOWS | |
| P # D | | < | Severe | Anemi | | | | | 1 | 1 day | |
|), executed n and iel-transit Examiner | Sequentially list conditions, | 0. | | or es e conseq | | | | | | | |
| | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c. S | idde Co | 11 Cr | กร์เร | | | | 3 | 3 days | |
| P.O. Box 68760 at the death certificate be established for use so the bunk Physician Physician Physician E | resulting in death) Last | d | Due to (d | or es e conseq | uence of): | | | | | | |
| Beath Seath Seath | Port II Other elegificant condition | na confebution to | doub but and one | uitia - la tha u | adachia - agusa | nives in Best I | 22h Dio | I tobacco use co | ntribute to | the cause of death? | |
| ~ 5 60 × | Pert II. Other significant condition | ris conmouting to | oeath but not res | suiting in the ur | nderrying cause | given in Pen I. | | Yee 2 No | | ably 4 Unknown | |
| of Vital Records, Physician: The law requires this certificate has been signeral director, page 2 should be e.: To Be Completed by | | | | | | | | s en eutopsy ormed? | ava | ore eutopsy findings illable prior to appletion of cause death? | |
| ital Remission The Hans The Hans The Hand Title Base Com | | | | | | | 1 🗆 | Yes 2KNo | 1□ | Yes 2□ No | |
| /ita | 25. Was case referred to medicat examiner? | | | | | | eeth (Check only | one) | | | |
| Division of Vital Rector the Hospital or Attanding Physician: The law within 24 burus after death. To the Funeral Director death. completely filled in by the fundral director, page 2. | 1 Yes 2 No 27. Menner of Deeth 1 Neturet 5 Pending 2 Accident investig | 28a. Dete (Mo | Inpatient 2 e of Injury onth, Day Year) | 28b. Time of Injury | 28c. In | | 4 | how injury occur | |) | |
| Division of an article of the function of an article of the function of in by the function: | 3 Suicide 6 Could n 4 Homicide determi | ned 200. Pled | ca of Injury - At h ding, etc. (Speci | ome, ferm, str | eet, factory, office | 20 | | (Street and Numb own, State) | oer or Rura | Route Number, | |
| he Hospitu in 24 hours he Funeral pletely fille | 29e. Certifier (Check only one) 156 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. | | | | | | | | | | |
| To the Mithin Comple | 29b. Signefure end fittle of certifier | | | | | nse number | | 29d. Date signe | 11: 11: 1 | | |
| | > Jehad L | akkls | | | P | 1257 | L | April | , 19 | , 1999 | |
| V p | 30. Name and address of person w | who completed car | use of deeth (Iter | m 23a) (Type, | Print) | Iniv Pkwa | y, Balti | | | | |
| State Registrar | 31. Dete filed (Month, Day, Year) APR 2 2 199 | 9 32. | Registrer's Sign | eture | books | | | | | | |

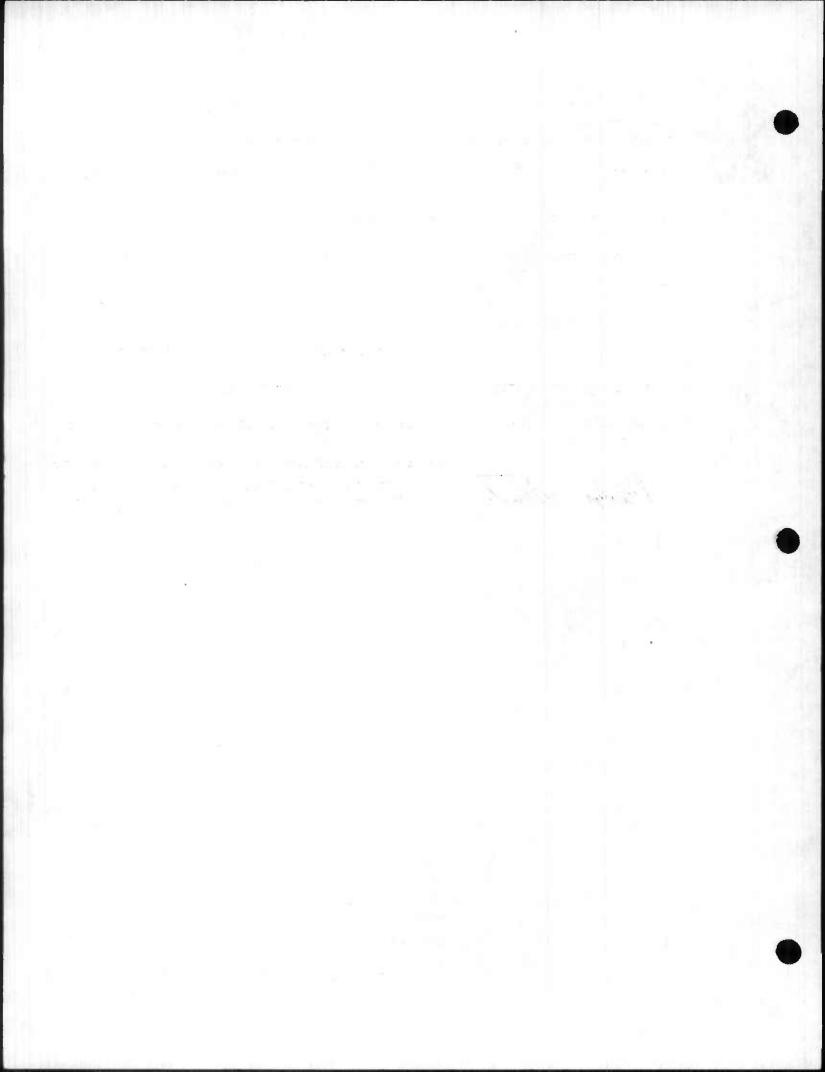
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 13997

| | | Cei | rtificate of Death | Rec | g. No. | 10001 |
|---------------------|--|---------------------------------------|--|--|---|--|
| nysician | Decedent's Name (First, Middle, Last) ELIZ-ABETH WH | ITE | | 2. Date of Death Month | Day Yea | 3. Tima of Death |
| Medical xaminer | Facility Name (If not institution, give straet and number | | 4b. City, Town, | or Location of Death | 4c. County of De | |
| | CHURCH HOME NURSING CENTE | | BALTIM | | | /A |
| eral ctor | 114-01-7839 1□M 2 □F | ge (In yrs. last birthday) 89 Yrs. | If Under 1 Year If Under 24 Hours N | frs. 8. Date of Birth (Month, Day, 1) JAN 4 1 | | irthplaca (Stata or Foreigi Country) ARYLAND |
| | sual Residenca of Decedent a. State 10b. County | 10c. City, Town or Lo | cation | | | 1011-11-02-11-5 |
| by Funeral Director | | | | | | 10d. Inside City Limits |
| 5 | MD HOWARD | ELLICOT | | | | 1 ☐ Yes 21€ No |
| al Director | e. Street and Number 3004 NORTH RIDGE ROAD | | 10f. Zip Code 21043 | 10 | g. Citizen of What (USA | Country? |
| by Funeral | Marital Status 1 ☑ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedant Armed Forces' 1 ☐ Yes 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedant Armed Forces' 1 ☐ Yes 2 ☑ Married 1 ☐ Yes 2 ☑ Married 1 ☐ Yes Give Yaar or Dates: | No I | Nas Decedent of Hispanlc Orlgin? f Yes, specify Cuban, Mexican, Pu l □ Yes 2 ☑ No Specify: | (Specify Yas or No- erto Rican, atc.) | 14. Raca - An Black, Wh | nerican Indian, lite, etc. |
| P | 15. Decedent's Education | 16a. Deced | lent's Usual Occupation | 10 | 6b. Kind of Busines | s/Industry |
| Completed | (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or | life. I | kind of work done during most of a DO NOT use retired) SECRETARY | | INSURANCE | COMPANY |
| | Father's Nama (First, Middle, Last) | | | lama (First, Middle, Ma | | COMPANI |
| Be | | | | | | |
| 2 | | | AGN | | | |
| | a. Informant's Name/Relationship (Type, Print) | 19b. Mallin | ng Address (Straet and Number or | Rural Route Number, | Cify or Town, State | , Zip Code) |
| | NNA LEIMKUHLER, SISTER | | NORTH RIDGE RD. | | | |
| | a. Method of Disposition | 20b. Place of Dispo cametery, crem | natory or other place) | Dete 20 | oc. Location - City of | or Town, State |
| | 4 □ Donation 5 □ Other (Specify) | | EMER CEMETERY | 4-19-99 | BALTIMORE | MARYLAND |
| ouce. | . Signature of uneral Service Licensee | 22 | . Name and Address of Facility | | | |
| 8 | Hulles Harla | | ERLING-ASHTON-S | | | |
| | Ba. Part1. Enter the diseasa, or complications that causa | d tha death. Do not ant | 6 EDMONDSON AVE | NUE, BALTI | MORE, MD | 21228 Approximate |
| | Ba. Part1. Enter the diseasa, or complications that causa shock, or heart failure. List only one cause on each in | ine. | and the three of dying, oddings out | nao or roophatory arros | | Interval Between Onset and Death |
| n il | mediate Causa (Final | 00. 1/40. | | | | |
| er | saese or condition a. USKB | BRO VASC | WLAR ACCID | 6141 | | grain |
| 70 | | | 001100 01/1 | | | year |
| Examiner | b. ATRIK | HL FIBR | ILLATION | | | gears |
| Xan | equentially list conditions, | Due to (or as a conseq | uenca of): | | | |
| | quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury | | | | | 1 |
| Medicai | at initiated events sulting in deeth) Last | Due to (or as a consequ | uenca of): | | | |
| Med | | | | | | 1 |
| 2 | d | | | | | 1 |
| Physician/ | t II. Other significant conditions contributing to death b | ut not resulting in the un | idedylna cause alven in Part I | 23h Did toh | ecco use contribu | te to the cause of death? |
| hys | > | at not resulting in the di | conying cause given in 1 ent i. | 1 Yes | . / | Probably 4 Unknown |
| by P | DEMENTIA | | | 1 1 101 | 2 2 MO 3 | Probably 4 Unknown |
| Completed b | | | | 24e. Wes an performe | | . Were eutopsy findings available prior to completion of cause |
| 문 | | | | | | of deeth? |
| ပိ | | | | 1 □ Yes | 2 No | 1 □ Yes 2 No |
| Be | Was case referred to medical axaminer? | | 26. Place of E | eeth (Check only one) | | |
| 2 | 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie | ant 2 ER/Outpatien | 3 DOA Other: 4 th Nursing | Home 5 ☐ Residen | ca 6 □Other (Sp | ecify) |
| | Menner of Death 1 DNatural 5 Dending (Month, Da | | 28c. Injury at Work? | 28d. Describe how | | |
| 읉 | 1 DNatural 5 Pending (Month, Da 2 Accident investigation | y Year) Injury | M 1 Yes 2 No | | | |
| Certification: | 3 Sulcide 6 Could not be determined 28e. Placa of Inj building, et | 28f. Location (Stre City or Town, | | Rural Route Number, | | |
| edicai C | a. Certifier (Check only one) Certifying Physician: To the best of the basis of th | r examination end/or inv | occurred et the time, date end ple estigation, in my opinion, death oc | ce, and due to the cau curred at the time, dete | se(s) end manner a and placa, and du | as stated. ue to the cause(s) |
| Mec | b. Signatura and title of certifier | ated. | 20c Licence number | 00- | Data slane d 44- | oth Day Voor |
| | | Salaineria | 29c. Liceosa number | 290 | I. Dete signed (Mor | mi, Day, rear) |
| | Mouverien med. | queialist | D40356 Broadway, F | A | PUL 15 | , 1999 |
| | Name end address of person who completed cause of d | eath (Item 23a) (Type, F | Print) | 7 | | |
| | JENELISA NAVARRO, M. | D. 100 K. | Broadway 7 | altimory. | Marylan | d 21231 |
| State | 0.100001 | ar's Signature | 1 | | 0 | |
| State | APR 2. 7. 1000 | no h | 1 | | | |



Physici /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Instortant if Item 27 is marked other than "natural", or frems 23s or 28s-f show any injury or other trainmatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificata be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | State of N | /laryland | - | artment rtificate | | | ind N | lental Hy | giene (| 9 | 132 | 869 |
|----|--|---|--|----------------------------------|------------------------------|------------------------------|--------------------------------|--------------------------|----------------------|--------------------------------|--------------------------------------|-------------|--|------------|
| 1. | Decedent's Nemo | e (First, Middle, Li | nst) | | | | | | | 2. Date of D | | | 3. Time o | of Death |
| 1 | | | | -0 | | | | | | Month | Day | Year | | |
| | DOYLE | | YEAGE | | | | 1 45 | On T | | | 15, 1999 | | 5:11 | PM. |
| 46 | Facility Neme (/ | I not institution, gi | ve street and numbe | r) | | | 40 | | | ocation of Dea | th 4c. County | of Death | | |
| | | LARFORD R | | | | | | PARK | | | | MORE | | |
| 5. | Social Security N | | Sex 7. A 1 □ M 2 □ F | Age (In yrs. las | | If Under 1 Months | Year Days | If Under : | 24 Hrs. Min. | 8. Date of Bi (Month, D | rth av. Year) | 9. Birth | place (State ntry) | or Foreign |
| 1 | 98-38- | 5511 | ILSM 2LJF | 51 | Yrs. | | , | | | AUG. 18 | | | JSYLVA | |
| | suel Residence of | | | | | | | | | | 1 | | | |
| | Da. Stete | 10b. County | | 10c. City, | Town or Lo | cation | | | | | | | 10d. Inside (| |
| 10 | MD. | BALTINO | DE | DADY | VILLE | | | | | | | | 1 Yes | 2 2 No |
| 11 | Da. Streat and Nur | | | 111100 | | 10f. Zip C | Code | | | | 10g. Citizen of N | What Cou | ntry? | |
| | 1000 | 1.05.00 | ~ ^ | | | | | | | | | - A | | |
| - | | the FOED | eD. | | | | 731 | | | | | .S.A | | |
| 1 | 1. Merilel Stalus | | 12. Wes Deceder Armed Forces | nt Ever in U,S. s?_ | 13. \ | Was Decede If Yes, specif | int of His y Cuban, | panic Orig Mexican | gin? (Sp , Puerto | ecify Yes or N Rican, etc.) | o- 14. Had | ck, White, | can Indian, etc. | |
| | 1 Never Marri | ied 2 Married | 1 Yes 2 | No | | 1 Yes 2 (| - | Specify: | | | Specifi | | | |
| | 3 Widowed | 4 Divorced | Year or Dates | : | | 105 20 | | opoury. | | | Specin | | HITE | |
| | 10 | 15. Decedent's E | ducation | | 16a. Deced | ient's Usual | Occupat | ion | | | 16b. Kind of B | usiness/Ir | ndustry | |
| | | eity only highest gr | | .5.) | life. L | kind of work DO NOT use | retired) | nng most | or won | ang | ED | UCAT | IMOI | |
| | Elementery/Seco | ndery (0-12) | College (1-4o | | ANI ED | C DIREC | CITAD | DUNC | CAI | EDUCATION | | | HIGH | CHANI |
| 17 | 7. Father's Neme | (First, Middle, Last | 0) | r | TINGETT | Chieco | - | | - | | e, Maiden Surnan | | HIGH | School |
| 5 | | | | | | | | | | | | | | |
| 2 | LEBOY | E. | YEAGER | 5 | | | | | | | SHELLE | | | |
| 1 | 9a. Informent's Ne | eme/Reletionship | (Type, Print) | | 19b. Mailir | ng Address (| Street ar | d Numbe | r or Rui | al Route Numi | ber, City or Town, | , State, Zi | p Code) | |
| | VANCY E | 3. YEAGI | ER. WIFE | | 10007 | HARFO | da | . Q3 | PARK | VILLE. | MD. 21 | 234 | | |
| 20 | Da. Method of Disp | | 1100 | | ce of Dispo | sition (Name | of place | | 1 | Date | 20c. Location - | | own, State | |
| | | | Removel from Stat | e E | TANS FL | NERAL | CHAP | EL | IA. | Pell 11, | - | | | |
| - | | narel Sarvina Lita | 1 | E | SEL AL | P - P | A | of Francisco | | 1999 | FOREST | HILL | MD. | |
| - | 3. Signaturardi Pu | Halla Saukan free | 0000 | | 22 | . Name and | Address | Of Fechin | EVA | NS CHAP | EL OF MI | emoe | HES | |
| | 1 Xa | To VALLE | | | 20 | 300 H | HADE | NOD | DI | DARL | WILLE. | мь | 71754 | |
| 2 | 3a. Pert1. Enter th | he diseese, or con | iplications that cause on each | ed the death. | | | | | cardiac | or respiretory | arrest, | | Approxima | |
| d | nmediete Cause (iseese or condition esulting in deeth) | Final n | . Cont | Due to (or a | | | Dous | ndo | fc | hest | | 1 1 1 | | |
| | equentielly list cor any, leeding to im ause. Enter Unde ause (Disease or | nditions, amediete crying Injury | 0. | Due to (or a | is a conseq | juence of): | | | | | | | | |
| th | nat initieted events esulting in death) L | | d. | Due to (or a | s a conseq | uence of): | | | | | | | | |
| | | | | | | | | | | | | I | | |
| P | ert II. Other signifi | cant conditions | contributing to death | but not resulti | ing in the u | nderlying cau | use giver | in Part I. | | 23b. Dic | tobacco use co | ntribute (| to the cause | of death? |
| - | | | | | | | | | | 10 | Yes 25540 | 3 Pro | obably 4[| Unknow |
| Pe | | | | | | | | | | | s an autopsy lormed? | 81 | Vere autopsy vailable prior ompletion of f death? | rto |
| | | | | | | | | | | 1 | Yes 2/21No | | ☐Yes 2[| 7 No |
| - | 5. Was case relen | rad to madt1 | | | | | | | | | | 1 | _ , es | _ 170 |
| | axeminer? | | Hospitel: | | | | Other | | | th (Check only | | | AT | |
| | 1 XYes 2 | | 1 L Inpa | | R/Outpatien | | 1 | 4 LI Nu | rsing H | | idence 6 XXVIII | | SCEN | VF. |
| 27 | 7. Menner of Death 1 Neturel 2 Accident | 5 Pending Investigation | 1 1 1 | lay Year) | 8b. Time of Injury 170 | M 28 | c. Injury a Work? 1 Ye | | No | 5elf-w | flicted | | hot w | ound |
| | 3d Suicide 4 ☐ Homicide | 6 Could not be determined | 259. Place of I | njury - At hom etc. (Specify) | e, farm, str | eet, fectory, | office | | | 28f. Location | (Street and Numb own, Stete) 10 o | ber or Rug | al Route Nu | mber. |
| | | | Sanding, (| (Spoony) | | home | | | | Parla | villa Mo | 9711 | urtord | Kd |
| 2 | 9a. Certifier (Check only one) | 1 Certifying Pt | hysician: To the bes miner: On the basis and manner: | of examinatio | edge, death n and/or inv | occurred at | the time | , date and nion, deal | d place, th occur | and due to the | cause(s) end man, date and place, | anner as | stated. to the cause | (s) |
| 21 | 9b. Signeture end. | Jitle of certifier | | | | 29c | License | number | | | 29d. Dale signe | d (Month | Day, Year) | |
| | ► Se | mi). | Chut is | | | | | C.M. | Ε. | h | APRIL 1 | | | |
| 30 | De was | ess of person who | pompleted cause of | | | | et, | Balt | imoi | re, Mar | yland 21 | 201 | | 2111 |

State Registrar Dete liled (Month Pay Pay) 2 1999 32. Registrar's Signature

B. Sparks

Value in the second of the

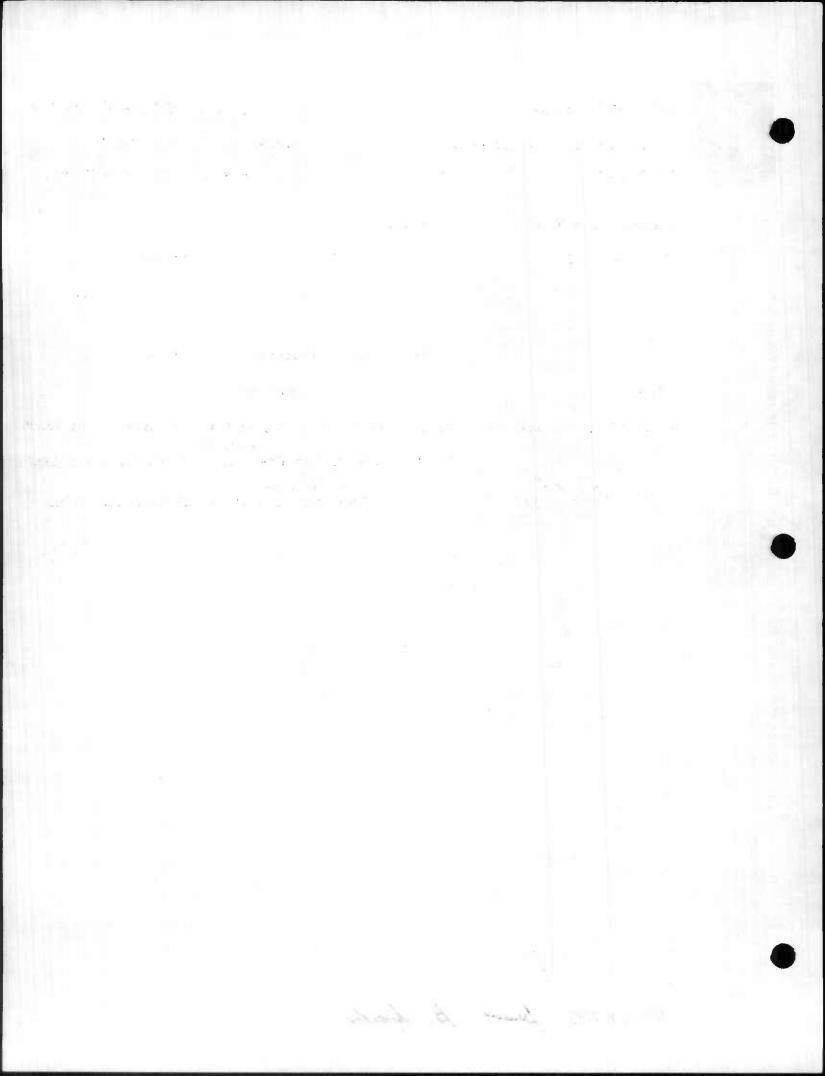
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey Year **Physician** APRIL
4b. City, Town, or Location of Deeth 08 1999 **EDNA** MAY 03:20 ALLEN /Medical 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner Elkton Union Hospital of Cecil County Cecil If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F Months Days Hours Min. Yrs. 99 **Director** 102-05-3747 October 7, 1899 New York Usual Residence of Decedent the Maryland 10d. Inside City Limits r 28a-f ahow anottfied at 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2XX No Director New Castle Delaware Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with the Department of Haalth and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Items 23s or 2) any injury or other traumatic event, the Maries In Maries 1980. 19702 3117 McDaniel Lane United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3₺ Widowed 4 Divorced Completed 18e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 Motel Owner / Operator Mote1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown 2 unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Jay Serbin / Personal Representative 4875 N. Federal Hwy, 4th Floor, Ft. Lauderdale F1 33308 April 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) North East Methodist Cem! 1999 North East, Maryland 21. Signature of Funeral Seattle Light 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death lan Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) neunonia Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of) attending pl signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown CANCE à 24b. Were autopsy findings available prior to completion of cause of death? been si 24e. Was en eutopsy Completed director, page 2 1 Yes 2 No 1 □ Yes 2 □ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etaly filled in by the funeral director, i 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death Certification: 12 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medical 29a. Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature end title of cortifier 33510 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 12 3 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

APR 0 8 1999



State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death ADT 1 Milton Abel1 4:45 A.M. 4a. Facility Nama (tf not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 9333 Bay Avenue Chesapeake Beach Calvert H Under 1 Year Months Days Hours Min. 8. Data of Birth (Month, Day, Year) Sept. 8, 1935 7. Aga (In yrs, last birthday) 6. Sex 1 M 2 F 9. Birthpiaca (Stata or Foreign Mary land Yrs 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Calvert Chesapeake Beach 10f. Zip Coda 10g. Citizen of What Country? 20732 USA 9333 Bay Avenue 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married Specify: White 1 ☐ Yas 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Russell Abe11 Doris Grinder 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4865 Strauss Ave. Indian Head, MD 20640 Barbara Cranford/Sister 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4/13/99 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 21. Signature of Funarai Sarvice Licenses 22. Nama and Addrass of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 9. Sewel 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart tallura. List only one cause on each line. Approximata Interval Between Onset and Death nears Dua to (organ a consequence of) Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 1 100 2 □ No 3 □ Probably 4 □ Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 P Rasidance 8 Othar (Specify) 140 SPICE 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physician /Medical **Examiner**

certificete be executed

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funerai

Director

item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: if fem 27 is marked other than "natural", or frema 23s any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

the Maryland

Gilbert

5. Social Security Number

10a. Stata

Maryland

11. Maritai Status

10e. Street and Number

Charles

Glady

Immadieta Causa (Final disaasa or condition resulting in death)

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

212-34-1069

Usual Rasidance of Decedant

Physician/Medical Examiner þ Completed Be

signed by the attending physician and I be detached for use as the burial-transit

paga 2 certificata this funeral After efter deeth. Director: Aft

peed has Certification: To

that initiated evants rasuiting in daath) Last

Medicai

29a. Certifian

(Check only one)

29b. Signatura and titla of certifian

25. Was casa rafarred to medical axaminar? 1 Yas 2 No 27. Manner of Death 1 Neturai 5 Panding

invastigation 2 Accident 3 ☐ Sulcida 4 | Homlcida

6 Could not be datermined

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28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

MIL

29c. Licansa number 004431

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rurat Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed ceusa ot daeth (Itam 23a) (Type, Print)

Edford O. Chambers, M.D. 31. Data filed (Month, Day, Year)

Prince Frederick, MD

State Registrar

32. Registrar's Signature



within 24 hours e To the Funeral D the Hospital

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) Day Month **Physician** William David Burkins 10 1999 2320 April /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year) March 5, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours 218-03-5026 78 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location mant be notified at 1 X Yes 2 No Director Maryland Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 806 Chesapeake Drive Nerns 23a U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46 14. Race - American Indian, 11 Meritel Status Black, Whita, etc. 1 ☐ Never Married 2 Married natural', or 1 Yes 2 No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Heelth and Mentel Hygiene. Important: If Item 27 ie marked other than "n any in jury or other traumate. V.A. Medical Center Elementary/Secondary (0-12) Twelve Years College (1-4or 5+) Perry Point, Maryland Transportation Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Edson L. Burkins Marietta Curry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred J. Burkins (wife) 806 Chesapeake Drive, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition Deta 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State West Nottingham Cemetery 4/15/99 Colora, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 10 min Examiner Due to (or as a cons Examiner 40 min physician and the burief-transit Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaese or Injury 110405 Physician/Medical that initieted events rasulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause 1 Yes 2 No 1 Yes 2 No 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 Tyes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and the of certifie 29c. License number 29d. Dete signed (Month, Day, Year) D40922

15 + IVA

State Registrar

WARISMANT THEU APR 1 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNION Avenue, HAVRE de Gresce 407 SOUTH 32. Registrar's Signature

Dr Wachsman

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Burkins, William

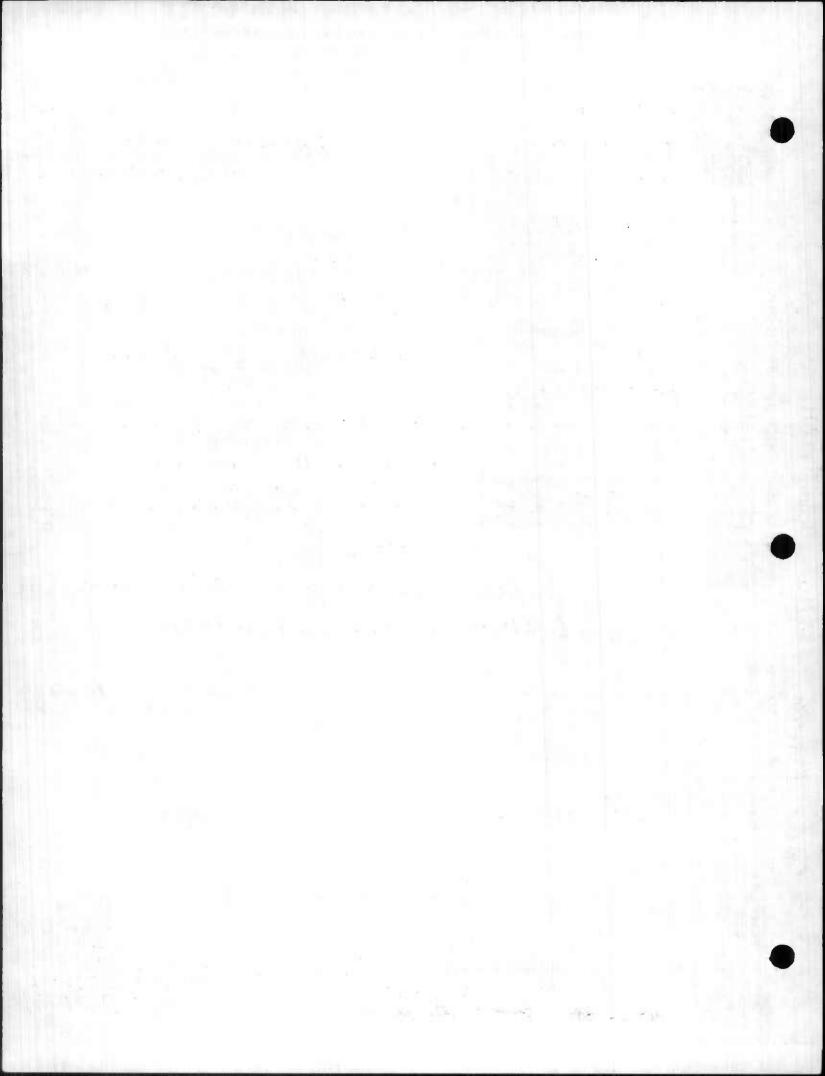


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 1-1- | 1. | 1. Decedent's Neme (First, Middle, Last) | | | | | | | | | 2. Dete d | | Day | Year | 3. Time of Dec |
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| | | Harford Mem | orial | Hospit | tal | | | l + | Havre | de | Grace | | Harf | ord | |
| rai | 5. | Social Security Number | | Sex | | rs. last birthday, | Months | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of (Month) May | f Birth | ear) | 9. Birthp | place (State or Fo |
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| rector | N | | ecil | | | Conowing | 1 | | | | | - 10 | | | |
| Director | 10 | De. Street and Number | | | | | 10f. Zip | | | | | | 10g. Citizen of What Country? | | |
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| Funeral | 11 | I. Maritel Status | | Armed F | | U,S. 13. | Was Deced | cedent of Hispanic Origin? (Spec pecify Cuban, Mexican, Puerto R | | | Pican, etc | r No- .) | | ce - Americ ick, White, | |
| by F | | 1 Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Div | | If Yes, G | 2 X No live | | 1 ☐ Yes 2 No Specify: | | | | | | Specia | fy: full | ito |
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| | | | - | | 19b Meit | ing Address | S (Street | | | | | ity or Town | . State Zin | Code) | |
| | 19e. Informant's Name/Relationship (Type, Print) Barbara J. Brinegar/Daughter 19b. Mailing Address (Street end Number) 521 Bell Manor Ro | | | | | | | conowi | | | | , 6666) | | | |
| | 20 | a. Method of Disposition | Diche | guttou | | D. Placa of Disposemetery, cre | | | | | Date | 7 | | - City or To | own, State |
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

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| | Funeral Director | | Sex 7. Aga (In) 1□ M 2X F 57 | vrs. last birthday) Yrs. | If Undar 1 Y Months De | ear If Undar 24 Hr. ays Hours Mir | | th Year) 1, 1942 | 9. Birthpi Coun Wes | laca (Stata or Foreig try) Uirgini |
| | Maryland -f show | Usual Rasidanca of Decedant 10a. Stete 10b. County Maryland Ce | cil 10c. | City, Town or Lo | | ing Sun | | | 10 | 0d. Inside City Limit |
| | Tec 128 | 10e. Street and Number | | | 10f. Zip Co | da | | 10g. Citizen of \ | What Coun | itry? |
| | Sa o | 216 Woody Brown | Road | | | 21911 | | U.S.A. | | |
| 020 | 2 should be filled within 72 hours after of end Mental Hygiene, 'naturel', or there werked other than 'naturel', or the reumetic event, the Medical Examine. To Be Completed by Fur | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Dacadant Ever in Armed Forces? 1 ☐ Yas 2X No If Yes, Giva Year or Datas: | | | of Hispenic Origin? (Cuben, Mexicen, Pua No Specify: | Specify Yes or Norto Rican, etc.) | 0- 14. Rac Blac Specify | en Indian, atc. White | |
| 2-0 | | 15. Decedant's E | ducation | 16a. Dace | dent's Usual O | cupation | ndkina | usinass/Ind | Justry | |
| 2121 | | Elementary/Secondary (0-12) Twelve Years | College (1-4or 5+) | lifa. | Homema | one during most of wo tired) iker | | Person | nal R | esidence |
| Maryland 21215-0020 | | 17. Fathar's Name (First, Middia, Las | Lee Stanley | | | 18. Mother's Na | | a, Maidan Sumen L. Church | , | |
| | | 19a Informent's Name/Relationship Albert I. Banks, | | | | reet and Number or Frown Road, | | | | |
| Baltimore, | 00- | 20a. Method of Disposition XXBurial 2 Cramation 3 [4 Donation 5 Other (Speci | Ramoval from State (fy) | 20b. Place of Disposition (Nama of cematary, cramatory or other place) CONOWINGO BADTIST | | | | 20c. Location - | | |
| Balt | parmit. Peg Department Important: I eny Injury o pnce. | 21. Signature of Funeral Service Lice | alter Dox. | \$ 22 L P | Name end A ee A. I errvvil | ddrass of Facility Patterson lle. Marvl | and 219 | 03-0188 | ome | |
| 1 | Physician /Medical Examiner | 23a. Part1. Entar tha disaasa, or con shock, or haart tailura. List only Immediata Causa (Final disaasa or condition rasulting In daath) | a Stage II | leath. Do not ent | cui cu | dylng, such as cardio | ac or rasptratory | arrast, | | Approximete Intervat Batween Onsat and Death |
| ox 68760, | ew requires that the death certificate be a set been signed by the attending physician 2 should be detached for use as the burnipleted by Physician/Medical E | | C | o (or as a consec | | | | | 1 | |
| ~ | | | contributing to death but not | rasulting in tha u | ndarlying ceus | e given in Part I. | | I tobacco use co | ontribute to | the cause of death |
| 9 | | | ar b - 75 | perl | s an autopsy lormed? | of o | ere eutopsy findings ailable prior to mplation of causa daath? | | | |
| je | ysicien: The list certificate he director, page | | | | | | | Yas 20 No | 1L | Yas 219No |
| Vital | Physician: this cartific ral director. | 25. Was casa retarrad to medical axeminar? 1 ☐ Yes 2 ☑ No | Hospital: | □ EB/O. 4=== | all pos | Other | eath (Check only | | os (Casaih | |
| o | £ £ # | 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accidant investigation | 28a. Date of tnjury (Month, Day Year | 2 ER/Outpatien 28b. Tima o Injury | | Injury at Work? 1 Yes 2 No | | ldanca 6 □Oth how Injury occur | | *// |
| Division | tal or Attending P is after death. I Director: After t ed in by the funers Certification: | 3 ☐ Suicida 6 ☐ Could not I 4 ☐ Homicide detarmined | | | raat, factory, of | lice | 28f. Location City or To | (Street and Numi own, Steta) | ber or Rura | I Routa Number, |
| | Nospital or At 24 hours after of Funeral Direct etely filled in by dical Certifi | | nysician: To the best of my minar: On the basis of axam end manner stated. | | | | | | | |

State Registrar

W. High St #104, Elkton, MO 21921

29c. Licanse number 035653

29d. Date signed (Month, Day, Year)

Phyllis Banks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year BARONY APRIL FRED 13 1999 10:45AM 4a. Facilify Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death 65 HIDDEN SPRING TRAIL BARSTOW CALVERT If Undar 1 Yaar If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1 ₹M 2□ F Days Yrs. 6, 1934 063-28-3059 Usual Residence of Decedant NEW YORK 64 MAY 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND CALVERT BARSTOW 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 65 HIDDEN SPRING TRAIL 20610 U. S. A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorcad WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elamentary/Secondary (0-12) College (1-4or 5+) AIRCRAFT QUALITY CONTROL TECH U. S. GOVERNMENT 12 18. Mothar's Name (First, Middla, Malden Surname) 17. Fathar's Name (First, Middla, Last) BERNICE CUNNINGHAM WALTER BARONY **JOHN** 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) WANDA L. BARONY/WIFE P. O. BOX 584 PRINCE FREDERICK, MARYLAND 20678 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata APRIL 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 16,1999 CLINTON, MARYLAND LEE CREMATORY 22. Name and Address of Facility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MARYLAND BLVD. OWINGS. MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, ck, or heart failure. List only one cause on each line. Approximate tnterval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only ona) examinar? 1 Yes 2 No Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

Box 68760. P.O. Records. Division of Vital

attending physician and for use as the burial-transit signed by the at d be detached for should I certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral illed in by completely

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

27. Manner of Death

1 Natural

2 Accident 3 Suicida

4 Homicida

29b. Signature and titla of cartifia

29a. Certifier

5 Pending

investigation

1999

6 Could not be determined

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at

"natural", or

d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than *r

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau

Physician /Medical

Examiner

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

State Registrar

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and piace, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and piace, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

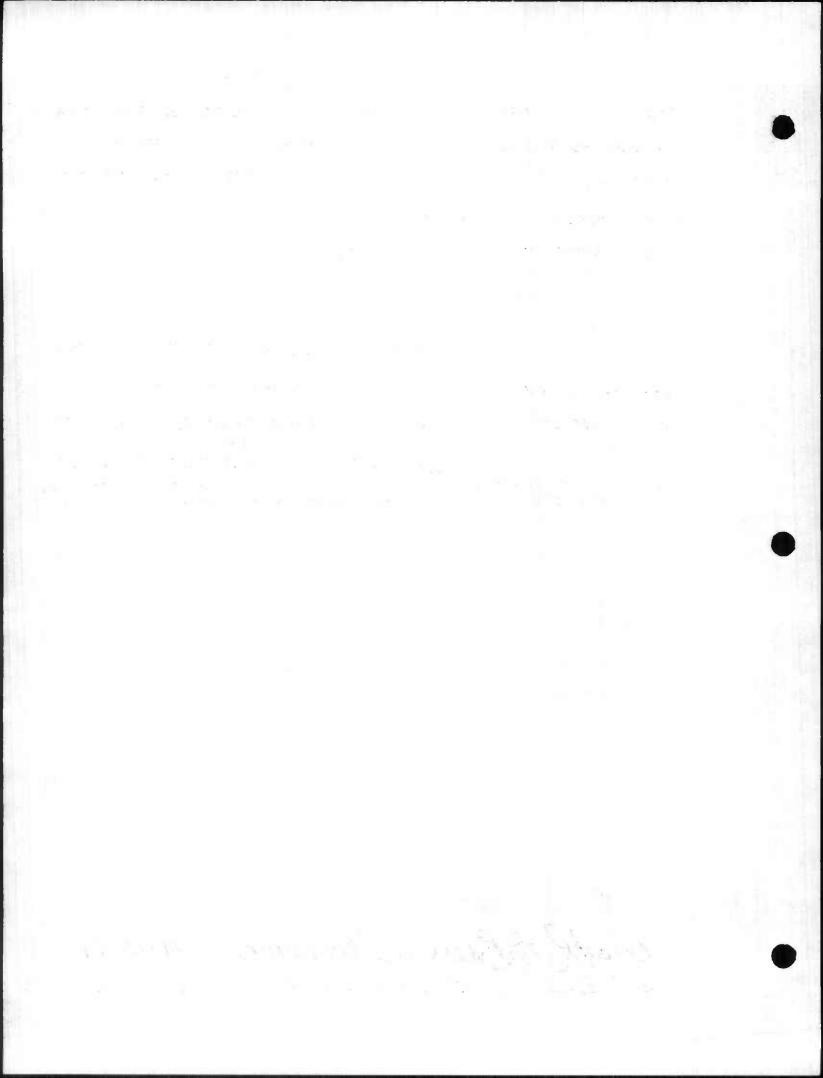
of death (Item 23a) (Type, Print) 30. Name and address of 1050 Solomons Island Rd. Prince Frederick, MD 20678 M.D 31. Date filed (Month, Day, Year) 32. Ragistrar's Signatura

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

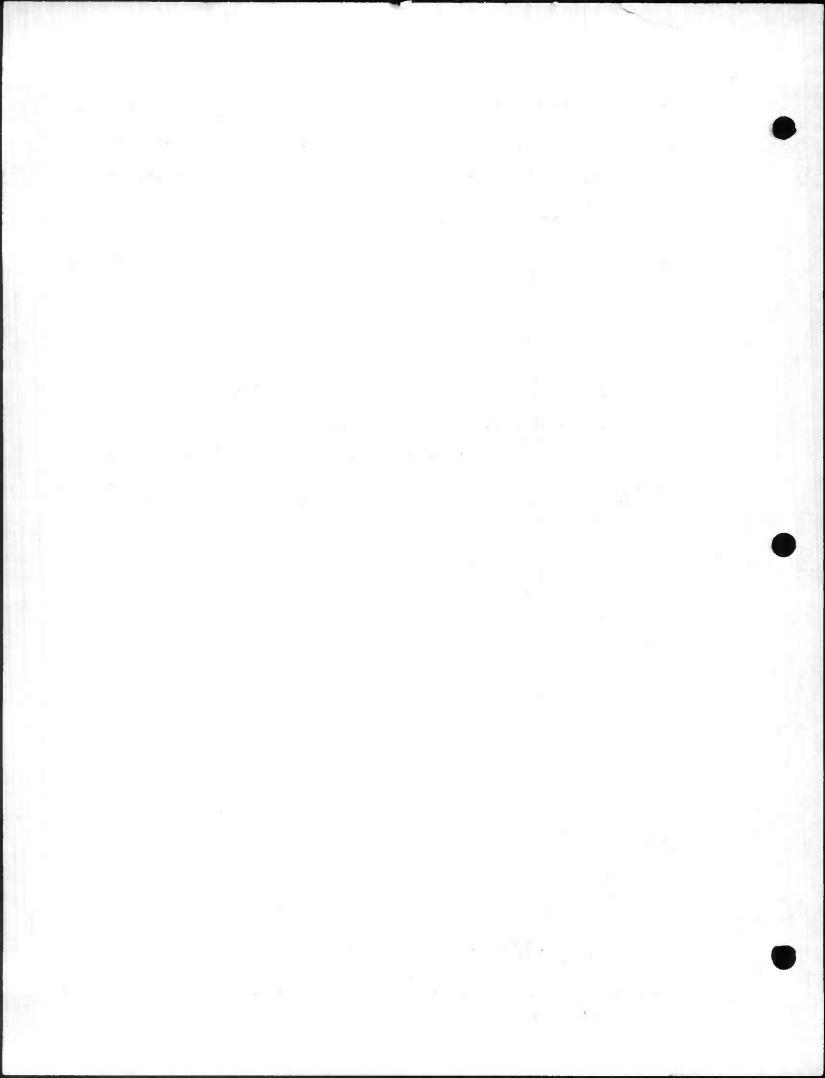
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

| | | | | | <i>y.</i> a | Cert | ificate of | Death | violitai 11y | Reg. No. | 1 . | 3596 | 5 |
|------------|---|----------------|--|---|-----------------------------|---|--------------------------------------|---|---------------------------------------|--------------------------------------|---------------------------------------|---|----------|
| ľ | | | 1. Decedant's Nema (First, Middla, Last) | | | | | | 2. Data of De Month | | Vaar | 3. Tima of | Death |
| | Physici /Medi | | Charlotte Emily | y Barret | t | | | | April | 7, 199 | 9 9 | 6:1 | 5 AM |
| | Examir | | 4a. Facility Nama (If not institution, give s | treet and number) | | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | |
| | | | 653 Running Fox | Rd | | | 1 | Lusby | | Calve | ert | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 214 30 8410 | M 2□ F X 6 | In yrs. last birt | hday) (rs. | If Undar 1 Yaar Months Deys | | 8. Dete of Bir (Month, Da March | th y, _{Year)} 31 1932 | 9. Birthpi Count Mary | ieca (State or try) 1 land | Foreign |
| | lend Ma | | 10e. Stete 10b. County | 1 | Oc. City, Town | or Loca | ation | | | | 10 | Od. Insida Cit | y Limits |
| | Many 1 sh | o | Maryland Calver | | | | | 1 🗆 Yes | 2 🖾 No | | | | |
| | r 284 | Director | 10e. Street and Number | | | | 10f. Zlp Coda | | | 10g. Citizen of What Country? | | | |
| | death wit | | 653 Running Fox Rd 20657 Uni | | | | | | | United | nited States | | |
| 21215-0020 | filed within 72 hours after death with the Marylend Hygiena. ther than "natural", or items 23a or 23a-f ehow wrt, the Medical Examiner must be notified at | by Funeral | | 2. Wes Decedant Ev. Armed Forcas? 1 ☐ Yas 2 ★No If Yas, Giva Yeer or Dates: | | | es Decedant of P Yas, specify Cub | dispante Origin? (Spen, Mexican, Puerto Specify: | pecify Yas or No o Rican, etc.) | | e - America ck, Whita, a y:Whit | atc. | |
| 5-0 | ed within 72 ho ed within 72 ho yojene. At the Medical Completed | | 15. Decedant's Educ (Specify only highast grada | ation completed) | 16a. | Deceda | nt's Usual Occup | pation during most of work | kina | 16b. Kind of B | usinass/Ind | lustry | |
| 2 | within 7 in within 7 in within 7 in wed or word omple | | Elamantary/Secondary (0-12) | Collega (1-4or 5+) | | lifa. Do | O NOT usa retire | during most of world) | A. I. G | | | | |
| | filed will Hygien other th. | | 11 | | hor | nem | aker | | | own ho | | | |
| and | Maryland 2127 d 2 should be filed within th and Mental Hygiene. The marked other the ten treumatic event, the ten To Be Compi | | 17. Father's Neme (First, Middle, Last) | | | | | 18. Mothar's Nam | | | na) | | |
| 7 | | | Lloyd Brittingha | | 106 | Helen M 19b. Mailing Addrass (Streat and Number or Rural Routa Num | | | | | Ctata Zia | Codel | |
| ∑ B | Mar nd 2 sho lith and 27 is m | | Terry Haire -day | - | | | as #1 | | rai riouta ivuilio | or, Only or Town | State, Zip | Coday | |
| Baltimore, | the series | | 20e. Mathod of Disposition 1 Buriai 2 Cremetion 3 Re 4 Donation 5 Other (Specify) | | 20h Place of | Dienosi | tion (Name of | ca) Y April | Dete 9 199 | 20c. Location Lusby | City or To | wn, Stete 7 land | |
| Balti | permit. Peges 'Department of Fire any Injury or of once. | | 21. Signature of Funeral Service Licenses | | | 22. | Neme end Addre | ess of Fecility | Rausch | Funera | al Ho | 2067 me P | |
| | | | 23a. Part1. Entar tha disaese, or compile shock, or haart failure. List only one | ations that causad th | a daath. Do n | ot antar | tha moda of dyl | omes Is. | or raspiratory a | rast, | Lauge | Approximata | |
| × | Physician | | | | | | | | | | İ | Intarval Betw Onsat and D | eath |
| ч | /Medical | | Immediata Causa (Final disaasa or condition | Meta: | stake | 2 | Brain | Lum | m | | | mh | |
| п | Examiner | | resulting in death) | Di | a to (or es e c | onsadu | ance of): | | | | | | |
| - | po te | ine | ■ h | J/a | beks | 1 | Telli. | Sus | | | i | | |
| | icete be executed physician and s the buriel-transit | Examiner | Sequentially list conditions, if any, leading to Immediate | | ua to (or as a c | | | | | | | | |
| 60 | be exictan | <u>60</u> | Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initieted avants c. | | | | | | | | | | |
| x 68760, | E 0 8 | /Medical | rasulting in deeth) Last | Du | a to (or es e c | onseque | ance of): | | | | i | | |
| .O. Box | the atte | Physician/ | Part II. Other algnificant conditions contri | ributing to death but i | not rasuiting in | tha unc | larlying causa gh | van in Part I. | | lobacco use co | | | |
| 0 | that the ned by detac | | | | | | | | 10 | Yes 2 No | 3 Prob | ebly 4551 | Jnknown |
| Records, | law requires that as been signed b | Completed by | | | | | | | | an eutopsy med? | ava | ra autopsy fi illable prior to npletion of ca death? |) " |
| E. | The law ate has page 2 | E | | | | | | | 10 | as 2 No | 10 | Yas 2□ | No |
| Vital | | Be | 25. Was casa rafarred to medical axaminar? | | | | | 28. Pleca of Dea | th (Check only o | na) | | | |
| of | | 2 | 1 Yes 2 No Ho | spital: 1 Inpatiant | 2 ER/Out | patiant | 3□ DOA Ott | har: 4□ Nursing H | oma 5 Rasi | dance 6 □Ott | ar (Specify | ') | |
| Division o | p te | Certification: | 27. Manner of Death 1 Natural 5 Panding 2 Accidant invastigation 3 Suicida 6 Could not be | 28a. Data of injury (Month, Day Y | (ear) 28b. T | ima of jury | 28c. Inju Wo M 1 □ | ryat rk? IYas 2□No | 28d. Dascribe | now injury occur | red | | |
| Divi | ital or Attendii is after deeth. el Director: A led in by the fu | Certifi | 3 Suicide 6 Could not be detarmined | 28a. Piece of Injury building, atc. (| - At homa, far (Specify) | m, strea | at, factory, offica | | 28f. Location (: City or Tox | Street and Num m, Stata) | per or Rura | l Routa Numi | oer, |
| / | To the Hospital or within 24 hours after To the Funerel Director Completely filled in E | ledical | 29a. Certifier (Check only 2 Medical Examine one) | cian: To the best of n ar: On the basis of a and mannar state | camination and | death o | stigation, in my o | opinion, daath occur | rred at tha tima, | data and placa, | and due to | the cause(s) | |
| | To To Too | Z | 29b. Signature and title of certifier | do | | | 29c. Licans | _ | | 29d. Date signe | | Day, Year) | |
| | i i | | () | m | | | D 3 | 7588 | | 489 | 9 | | |
| | | | 30. Nama and addrass of person who com | pleted causa of daal | th (Itam 23a) (| Гуре, Р | rint) | | | | | | |
| | | | Rafik Nasr, M.D. 31. Data filed (Month, Day, Year) | . 135 W. | Dare | s_E | each R | d. Prin | ce FRe | derick | Md | 20678 | |
| | Sta Registr | | APR 0 8 | | Signatura | | 4 1 | north/ | | | | | |
| | negisti | aıı | 14 1/ U O | בעבו | 7 | | - 12/0 | COURS! | | | | | |

DHMH 16 Rev 6/95



Months

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| 9 | 0 | 5 | 0 | 6 |
|---|---|-------|---|---|
| 1 | 1 | 1 | 1 | 1 |
| i | U | h 100 | 2 | 0 |

| Physician | |
|-----------|--|
| /Medical | |
| | |
| Examiner | |

Director

Funeral

à

Completed

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

220 14 6303

BOWERSOX GEORGE

2. Date of Deeth APRIL 6, Day APRIL 6, 1999 3. Time of Deeth 23:30

4a Facility Neme (If not institution, give street and number) Calvert Memorial Hospital

4b. City, Town, or Location of Death Prince Frederick

4c. County of Death Calvert

8. Date of Birth AMOUNT, Dey, Year 1927 Maryland

Funeral Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar maint be notified as

permit. Pages 1 and 2 should be filed within 72 hours efter deeth Department of Health end Mentel Hygiene. Important: If item 27 Is marked other than "natural", or theme 23 any Injury or other traumatic event, in the Medical Examine man

any la

Physician /Medical

Examiner

physicien and the burial-tren

ed by the edetached

signed by ti

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Seu

certificete

After this funeral

within 24 hours efter deeth. To the Funersi Director: Al

illed in by

Hospital or Attending Physician:

e fi

10

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

þ

Completed

Be

2

Certification:

edical

with the Meryland

Usual Residence of Decadent 10a State 10b. County Maryland Calvert

10c. City. Town or Location St. Leonard

Yrs.

7. Age (In yrs. lest birthday)

10d Inside City Limits 1 Yes 2 No

Birthplace (State or Foreign Country)

10e. Street and Number

1561 Calvert Beach Road

10f. Zip Code 20685

Deys

10g. Citizen of Whet Country? United States

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Hours

14. Reca - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

College (1-4or 5+)

1GM 2□ F

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tractor trailer driver

1 Tyes 2X No Specify:

16b. Kind of Business/Industry

Transport

17. Father's Name (First, Middle, Last)

Frank Harvey Bowersox

18. Mother's Name (First, Middle, Maiden Sumame) Irene Victoria Struder

19a. Informent's Name/Relationship (Type, Protother Franklin D. BowersoxSr-

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20685 P.O. Box 245 1561 Calvert Beach RD. St. Teore 20c. Location - City or Town, Stete

20a. Method of Disposition

1 Burial 2 XCremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) | 8

Metropolitan Funeral Service

Alexandria Virginia

21. Signature of Funeral Servica Licensee

22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Part Republic Maryland 20676

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRMONY FAILURE
Due to (or as a consequence of):

Approximete Interval Between Onset and Deeth

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

ALDIO MY OF ATHY
Due to (or es a consequenca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

CHRONIL

OMTHURVE

PUL.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown

DEMENTIA

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 200 No

25. Was case referred to medical exeminer?

1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes TNo 27. Manner of Death

5 Pending investigation

6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

1. Natural

2 Accident

3 Sulcide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number

29b. Signeture end title of cartifier

MD

50249

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

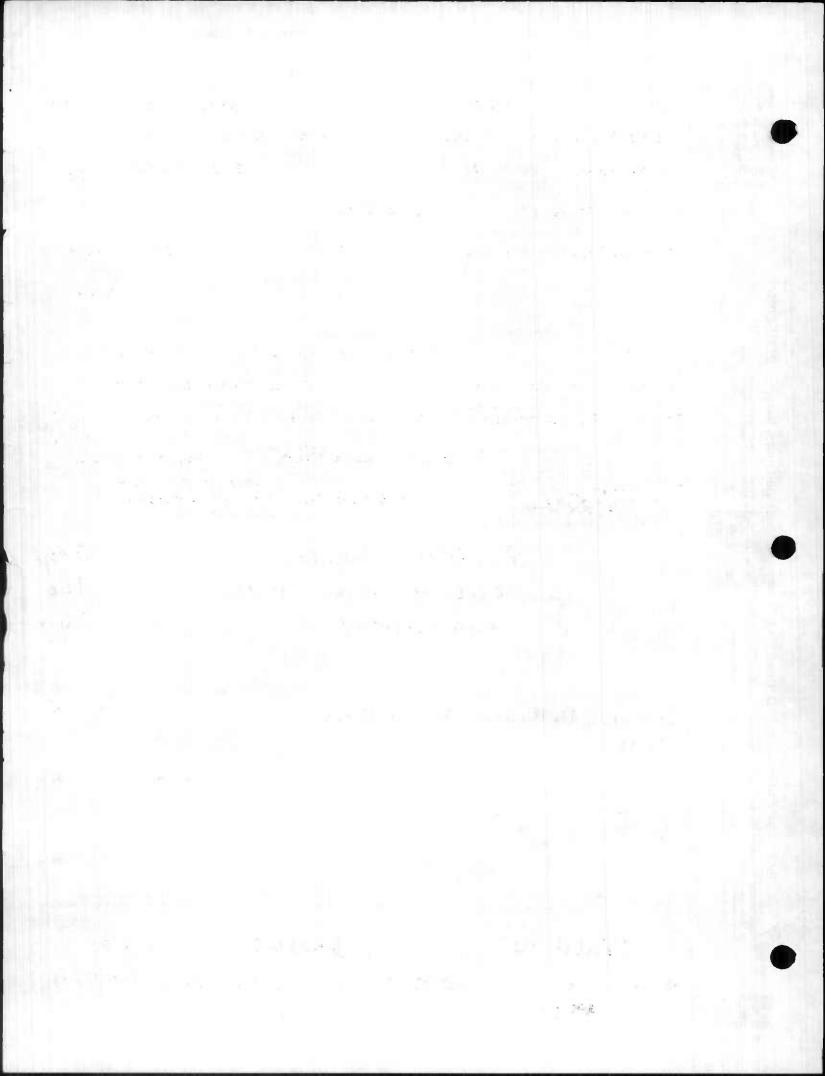
MATEL 31. Date filed (Month, Des

HOJPITAL

PR-FREDGAUL, #303

State Registrar

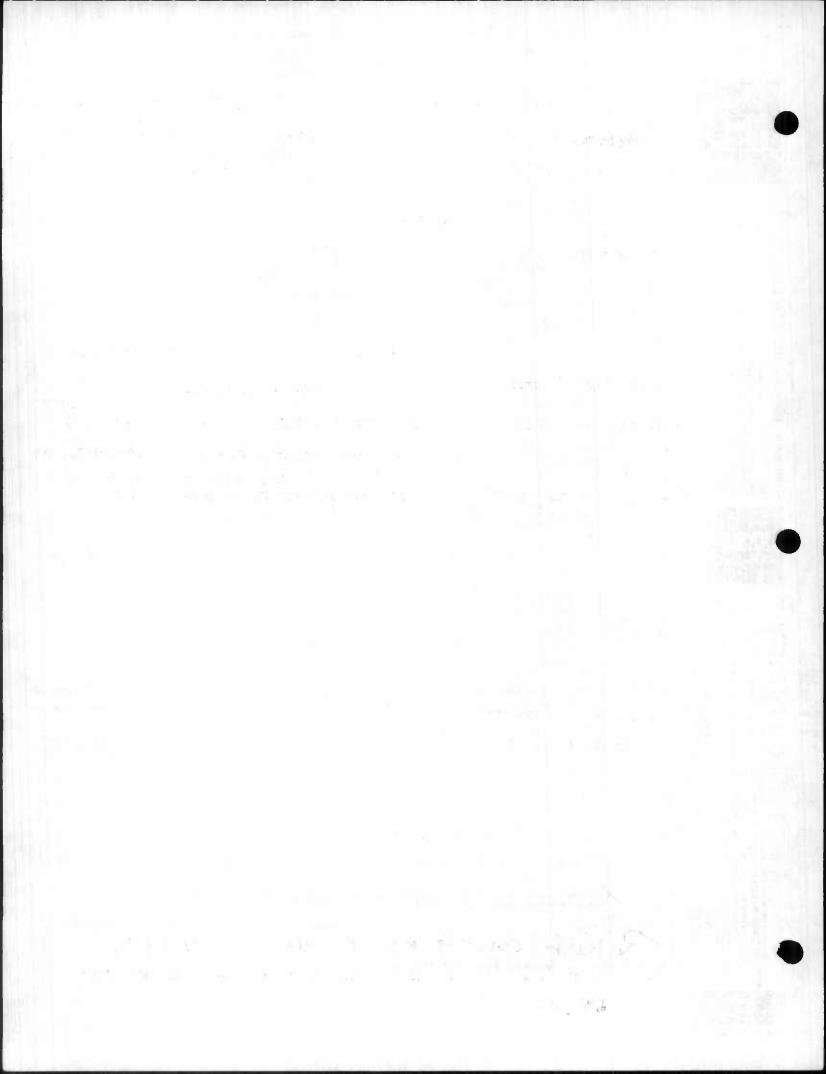
32. Registraris Signature 1999 ▶



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Na | me (First, Middle, L | ast) | 001 | rtificate of | | 2. Date of Dee | leg. No. | 1: | 3. Time of Death | |
|-------------------------|--|---|--|--|---|---|---|--|---|---|--|
| ysician | Ro | bert Dou | glas Ci | mmins | | | April | 3, Day 1999 | Year | 4:30 P.M | |
| Medical aminer | | | ive street and number) | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | |
| | Do | octors H | ospital | | | Lanham | | Princ | e Geor | ge's | |
| eral ctor | 5. Sociei Security | 3548 | Sex 7. Age (| In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day 1 Year) 1930 Sinthplece (State or For Country) March 12, 1930 Maryland | | | | |
| | Usual Rasidance 10a. State | 10b. County | 1 | Oc. City, Town or Lo | cation | | | | 10d | inside City Limits | |
| by Funeral Director | MD | P.G. | Т | Jpper Marl | lbom | | | | | 1 ☐ Yes 2 💢 No | |
| Je C | 10e. Street and N | umber | | pper mari | 10f. Zip Code | | 1 | Og. Citizen of V | Vhat Country | 7 | |
| al D | 4210 La | argo Road | P.O. Box 5 | | 207 | 773 | | United | | | |
| by Funeral Director | | rried 2 Merried | 12. Was Decedent Ev Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Detes: | | Was Decedent of I- f Yes, specify Cub 1 ☐ Yes 2 ☐ No | Hispanic Orlgin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | e - American k, White, etc. | | |
| Completed | (Sp | 15. Decedent's E ecify only highest ge condary (0-12) | Education rade completed) Collage (1-4or 5+) | 1/10. 1 | ient's Usuel Occup kind of work done DO NOT use retire | pation during most of work d) | ing | 16b. Kind of Bu | isiness/indus | try | |
| Con | 8tl | n | | | intenance | 9 | | P.G. | Govern | ment | |
| Be | | e (First, Middle, Las | | | | 18. Mother's Nam | e (First, Middle, I | Maiden Sumam | (e) | | |
| 2 | Richard | chard Douglas Cummins Mildred Fmma Bing ormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City | | | | | | | | | |
| To | 19a. informant's | Name/Relationship | (Type, Print) | | | | | | | | |
| alper t | | d Watson | | | | oad P.O. I | | | - | | |
| 5 | 20a. Method of Di 1 ☑ Burial | • | Removal from State | 20b. Place of Dispo cemetery, cren | natory or other pla | ce) | | 20c. Location - | | | |
| | | 5 Other (Special | ** | | | Methodis | | | | | |
| 9505 | | | | | | | | ee Funeral Home, Inc 6633 Old Rd, Clinton, MD 20735 | | | |
| ian cal | Immediate Cause disease or condit | (Final | one cause on each line. | | | ng, such as cardiac | or raspiratory arre | est, | Or | proximata terval Batween aset end Deeth | |
| ner: | resulting in death | | | e to (or as a conseq | | | | | 10 | ears. | |
| nec | | 100 | Athe | roscli | 21700 | | | | | 001 - 0 | |
| Examiner | Sequentially list of | onditions, | | e to (or as a conseq | 1 | | | | 1 | tary. | |
| | Sequentially list of if any, leading to cause. Enter Unc Cause (Disease of | mmediate ferlying r injury | | | | | | | | | |
| edical | that initiated even resulting in death | ts . | Du | e to (or es a consequ | uence of): | | | | | | |
| | | L | d | | | | | | | | |
| cian/M | | 11 123 | 024 | | | | | | | | |
| Physician/N | | | contributing to death but n | | - | van in Part I. | 23b. Dld to | | tribute to the | e cause of death? | |
| | Sev | ere | 1 tremi | 9 | | | 1 🗆 Y | 2 XNO | 3 Probabi | ly 4 ☐ Unknown | |
| Completed by | Me | entul | Anemi | dati | DN . | | 24a. Was a parform | n autopsy ned? | availat | autopsy findings ble prior to etion of ceuse th? | |
| Comp | | | | | | | 1 □ Ya | s 2 No | 1 □ Y€ | es 2 No | |
| | 25. Was case refe | rred to medical | | | | 26. Place of Deat | | | | | |
| 100 | examiner? | X _o | Hospital: | 2 ER/Outpatien | 3 DOA Oth | AP. | me 5 ☐ Reside | | or (Specify) | | |
| 0 | | | 28a. Data of Injury | 28b. Time of | | | 28d. Describe ho | | | | |
| 2 | 27. Manner of Des | | | a of Injury 28b. Time of Injury 28c. Injury at Work? M 1 □ Yes 2 □ No | | | | | | | |
| 2 | 1 Natural 2 Accident | 5 Panding Investigation | n | | 3 Suicide 4 Homicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) | | | | | | |
| cation: To | 1 Natural 2 Accident 3 Sulcide | 5 ☐ Panding Investigation | 28e. Place of Injury | - At homa, farm, stre Spacify) | eet, factory, office | | 28f. Location (St. City or Town | reet and Numbe n, State) | er or Rural Ro | oute Number, | |
| dical Certification: To | 1 Natural 2 Accident 3 Sulcide | 5 Panding Investigation 6 Could not be detarmined | 28e. Place of Injury | Spacify) by knowledga, death amination and/or inv | occurred at the tin | ne, data and place | City or Town | n, State) | nnar se etator | 4 | |
| Certification: To | 1 Natural 2 Accident 3 Suicide 4 Homicide | 5 Panding Investigation 6 Could not be detarmined Certifying Pt Medical Exam | 28e. Place of Injury building, etc. (s) | Spacify) by knowledga, death amination and/or inv | occurred at the tin estigation, in my of | ne, data and place, pinion, death occurr a number | City or Town | n, State) | nnar as stated | d. o causa(s) | |
| dical Certification: To | 1 Actival 2 Accident 3 Sulcide 4 Hamicide 29a. Certifler (Check and) | 5 Panding Investigation 6 Could not be detarmined Certifying Pt Medical Exam | 28e. Place of Injury building, etc. (s) | Spacify) by knowledga, death amination and/or inv | occurred at the tin estigation, in my of | ne, data and place, pinion, daath occurr | City or Town | n, State) ause(s) end mar ate and place, a | nnar as stated | d. o causa(s) | |
| dical Certification: To | 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture an | 6 Panding Investigation 6 Could not be detarmined Certifying Physical Example of certifier | 28e. Place of Injury building, etc. (s) 28e. Place of Injury building, etc. (s) Typelcian: To the best of minar: On the basis of exand mannar stated | iy knowledga, death amination and/or inv | occurred at the tine estigation, in my or 29c. License | me, data and place, pinion, daath occurr a number | City or Town and due to the ce ed at the time, de | ause(s) end mai ate and place, a 9d. Date signed | nnar as stated and due to the (Month, Day | d. causa(s) , Year) | |

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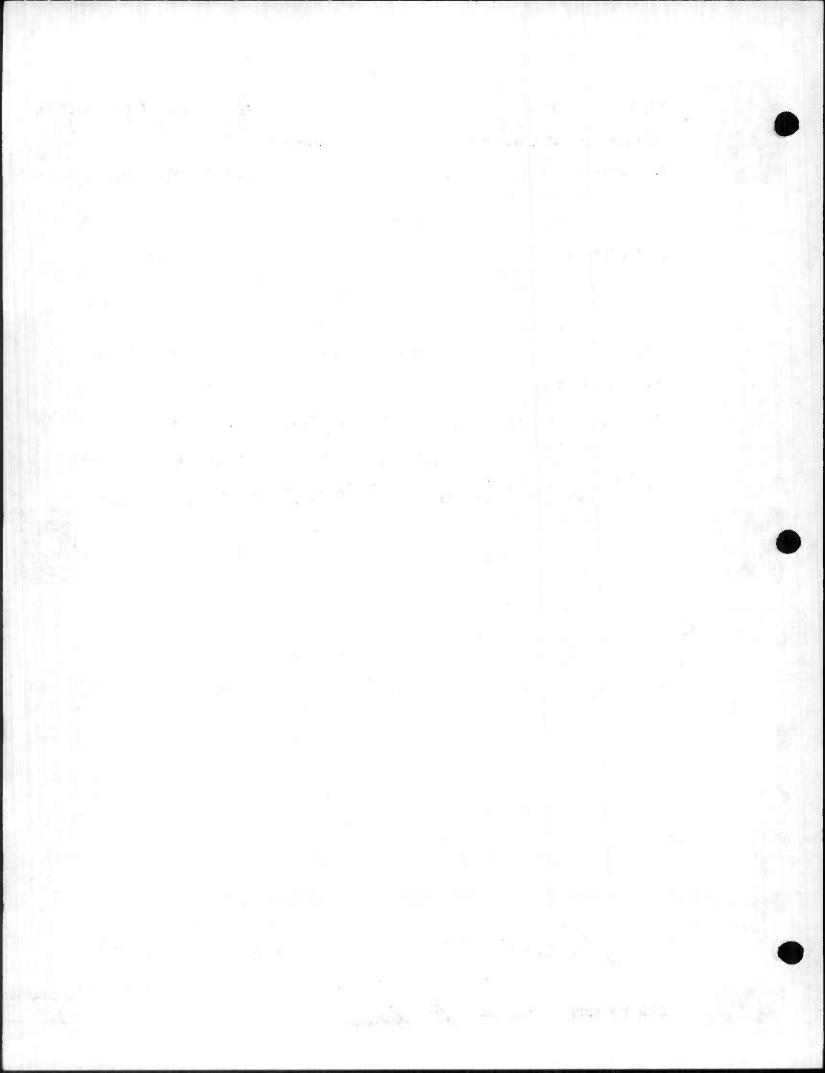
| | 4 December Name (First Middle Local | State of Maryland | Certificate of | Death | | 3. No. 99 | 3. Time of Death |
|--|---|---|--|--|-------------------------------------|--|--|
| Physician /Medical | Donald James Donald James | | | | Month APRIL | Day Year 7, 1999 | 8:14am |
| Examiner Funeral Director | 4a Facility Name (II not institution, give 191 Birchwood 5. Social Security Number 6. Security Number 221–22–3953 | Lane | st birthday) If Under 1 Yea Months Day: | s Hours Min. | 8. Date of Birth | Kent (ear) 9. Bin C 1938 Pe | nthplace (State or Foreign ountry) |
| dand ww | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Location | | | | 10d. Inside City Limits |
| with the Maryland e or 28s-f show be nottled at | MD Kent | Gal | lena | | | | 12€) Yas 2 □ No |
| vith the Mar or 28a-f s be notified Director | 10e. Street and Number | | 10f. Zip Code | | 100 | g. Citizen of What C | ountry? |
| or items 23 infort man | 191 Birchwood 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | Lane 12. Was Decedent Ever in U.S. Armed Forcas? 125 Yes 2 □ No If Yes, Give Year or Dates: 55-57 | | Hispanic Origin? (Spec ban, Mexican, Puerto R | ify Yes or No- ican, etc.) | U.S.A 14. Race - Am Black, Whi Specify: | arican Indian, |
| 5 1 5 | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | cation | 16a. Decedent's Usual Occ | e during most of working ed) | U | Sb. Kind of Business niv. of aintenar | Delaware |
| B very | 17. Fathar's Nama (First, Middla, Last) Robert E. Dras | s | | 18. Mother's Name | (First, Middle, Ma | | |
| | 19a. Informant's Name/Relationship (T) | | 19b. Mailing Address (Street | | | - | |
| item 27 le other tra | Carol Drass 20a. Method of Disposition | 000 | 191 Birchw ce of Disposition (Name of natery, crematory or other p | | | a , MD | A CONTRACTOR OF THE REAL PROPERTY AND ADDRESS OF THE REAL PROPERTY |
| nent of ury or o | 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) | temoval from State | aware Veter | | /12/99 | Bear, | DE. |
| permit. Page Department if Important: if any injury on page. | 21. Signature of Funeral Service Doesn 23a Part Entry the disease or complainted, or round failure. List only o | M00510 | 118 W. Do not enter the mode of d | Funeral H Cross St. ying, such es cardiac or | Gale: | na, MD. | 21635 Approximate |
| ocean certificate be executed with the property of the propert | Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | ses with as a consequence of): The Righton as a consequence of): as a consequence of): | Respira | fory For | Connen | |
| d by the attending pletached for use as the Physician/Mec | Part II. Other significant conditions co | d | ing in the underlying cause of | oiven in Part I | 23b. Did tob | acco use contribut | to the cause of death? |
| een signed by the hould be detached eted by Physic | to BACCO ATSU | | fussin, | Sepression | 12 Yes | | Probably 4 Unknown |
| 2 should | | | | | 24a. Was en performe | | Were autopsy findings available prior to completion of cause of death? |
| cate he | | | | | 1 ☐ Yes | 2 1 No | 1 Yes 2 No |
| s certificate director, pa | 25. Was case referred to medical examiner? | fospital: 1 ☐ Inpatient 2 ☐ El | R/Outpatient 3 DOA | 26. Place of Death | | | ecity) |
| | 27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation | | 8b. Time of Injury 28c. Injury | | 8d. Describe how | | ouny) |
| 4 hours after deeth. Funaral Diractor: After they filled in by the funeral lical Certification: | 3 Sulcide 6 Could not be determined | 28e. Place of Injury - At hom building, atc. (Specify) | ne, farm, street, factory, office | 9 25 | 8f. Location (Stre City or Town, | | Rural Route Number, |
| Funer Funer stely fill dical | | sician: To the best of my knowledge: On the basis of examination and manner stated. | | | | | |
| To the comple | 29b. Signatura and title of certifiar | 0 | | nse number | 290 | d. Date signed (Mor | oth, Day, Year) |
| , | Muals | 3 | De | 23889 | | 4/71 | 99 |
| 8+ IVA State Registrar | 30. Name and address of person who co TO Law C - APCK My 31. Date filed (Month, Day, Year) APR 0 8 1999 | | 94FWASL | uigten Av. | e, CIX | er here for | m Ked 21G20 |

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ent of the second state of the second

| | | 1. Decedente Name (First Middle Lees) | of Death | - | Reg. No. | 1 10 100 01 01 | |
|--|---|--|--|--|---|--|--|
| Physic | | 1. Decedant's Nama (First, Middla, Last) Raymond T. Edwards | | 2. Data of De Month | Dey | Year | |
| /Medi Exami | | 4a. Facility Nama (If not institution, giva straet end numbar) | 4b. City, Town, or I | April Location of Deeth | | 1999 3:00 F | |
| Funeral Director | P | Sunrise Care & Rehabilitation Center 5. Social Sacurity Number 6. Sax 1 \times 1 \times M 2 \square F 7. Age (In yrs. last birthday) Months 1 Usual Rasidance of Dacadant | Elkton Year If Undar 24 Hrs. Days Hours Min. | (Month, Da | Ce th y, Year) | Cil 9. Birthplaca (Steta or For Country) North Caroli | |
| Wo | | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. tnsida City Li | |
| Fig. | to | Delaware New Castle Newark | | | | 1 X Yas 2 | |
| or 28 | Jr ec | 10e. Street and Number 10f. Zlp Co | oda | | Whet Country? | | |
| 230 | rai | 1141 Elkton Rd. | 19711 | | USA | SA | |
| jene. r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at | by Funeral Director | 1 □ Navar Marriad 2 □ Married 1 🔀 Yas 2 □ No . | nt of Hispanic Origin? (Sp. Cuban, Mexicen, Puerto No Specify: | pecify Yas or No o Rican, atc.) | - 14. Rad Ble Specifi | ce - American Indian, ck, Whita, atc. Y: White | |
| e. an "natura Wed call | Completed | 15. Decedant's Education (Spacify only highast grada complatad) Elementary/Secondary (0-12) College (1-4or 5+) | Decupation dona during most of work ratired) | king | 16b. Kind of B | usinass/Industry | |
| ygien t. In | Con | 12 Owner/Oper | ator | | Pall | et Mfg. | |
| and Mental Hygiene. Is marked other than sumatic event, me M | To Be | 17. Fethar's Nama (First, Middla, Last) Quincy G. Edwards | 18. Mothar's Nam | na (First, Middla, Lyn McCa. | | na) | |
| 2 8 E | | | | | | | |
| item 27 I | | Sharon A. Notarcola/Daughter PO Box 11 20a. Mathod of Disposition 20b. Place of Disposition (Nama | | lle, MD | | | |
| Department of I Important: If ite any injury or or once. | | 1 Surial 2 Cramation 3 Ramovei from Stata 4 Donation 5 Other (Specify) Memorial Cem | ar placa) | Data 4-16-99 | | City or Town, Stata Delaware | |
| Impor any in | | 21. Signeture of Funarai Service Licansee 22. Nama and A | Addrass of Facility | P Home | P. A. | | |
| ysician Medical aminer | | 23e. Part1. Enter the disease, or complications of coused the death. Do not antar the mode of shock, or heert failure. List only one caus of each line. Immediate a use (Final disease or on onlition a. ACUTE MYOCARD resulting if death) | | or raspiratory ar | rest, | Approximate Interval Batweer Onsat and Deatl | |
| Medical aminer phopological aminer transit the prival transit | Aedical Examiner | 23e. Part1. Briter tha disaasa, or complications of cousad tha death. Do not antar tha mode of shock, or heert failure. List only one cause of each line. | of dying, such as cerdiac | or raspiratory ar | rest, | Approximate Interval Batweer Onsat and Daat | |
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| by Strate this certificate has been signed by the attending physician end in properties of the funeral director, page 2 should be detached for use as the buriel-transit in by the funeral director, page 2 should be detached for use as the buriel-transit in properties of the properti | Medical Certification: To Be Completed by Physician/Medical | 299. Signature and tible of certifying Physician: 290. Signature and tible of certifying Physician: 291. Signature and tible of certifying Physician: 292. Lie. 293. Signature and tible of certifying Physician: 294. Signature and tible of certifying Physician: 295. Signature and tible of certifying Physician: 296. Signature and tible of certifying Physician: 297. Lie. 298. Signature and tible of certifying Physician: 298. Signature and tible of certifying Physician: 298. Signature and tible of certify | 26. Placa of Deet Other: 41 Wursing Ho Injury at Work? 1 Yas 2 No ffice ha time, data and place, my opinion, daath occurricanse number | 23b. Did t 1 1 Y 24a. Was performed to the company of the Check only or the company of the compa | obacco use convises 20 No an autopsy rmed? 'es 20 No na) lance 6 Oth now injury occurs straat and Numb m, Steta) sausa(s) and me data and place, so 29d. Dete signed | Approximate Interval Batweer Onset and Daet Similar al Batweer Onset and Daet Similar al Batweer Onset and Daet Similar al Batweer Onset and Daet Similar al Batweer Onset and Daet 1 | |

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 999 05:03PM MOIN 10 06 /Medical 4a Facility Nem (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 14, 1916 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye 9. Birthplace (State or Foreign **Funeral** 10M 20F Months Days Hours Country) Mary Land 82 219-58-9373 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director Calvert 28a-f Maryland Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2818 Dalrymple Road 20689 USA flams 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygienu. Important: if Item 27 is merked other than "natural", or Item stry injury or other traumatic event, the Medical Eventues. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 Specify: Black 1 Yes 2 No Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be James Holland, Sr. E11a Green 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8502 Dark Hawk Circle Columbia, MD 21045 C. Vernon Gray/Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 Cremation 3 Removal from State 4/12/99 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UMC Cemetery Sunderland, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signeture of Funeral Service License 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of): physician s the burial Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were sutopsy findings available prior to 24a. Was an autopsy completion of cause of death? 25 40 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Appatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dev 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Panding investigation 1 Matural 1 Tyes 2 No 24 hours after death.

Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

completaly

within 2 4

6

(Check only one)

completed cause of death (Item 23a) (Type, Print)

32. Regisfrar's Signeture

29c. License number

29d. Date signed (Month, Day, Year)

olumbo

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Certificat | o or bourn | | Reg. No. | | | |
|---|---|--|---|--|--|---|--|--|--|--|--|
| sician | 1. Decedent's Nan | me (First, Middle, La | | | | 2. Date of D Month | eath Dey | Yeer | 3. Time of Death | | |
| edical | Darlen | | 2 | oove | | | ٥ | 4 01 | 99 | 2155 | |
| niner | 0. | | re street and number) | , , . | 110 | | n, or Location of Dea | | of Death | _ | |
| | 5. Social Security | | Sex 7. Ag | e (in yrs. last b | The state of the s | r 1 Year If Under 2 | | | | ace (Stete or Foreign | |
| | | 6-0720 | 1 M 2 S F | 45 | Yrs. Months | | Min. (Month, 2 | nth, Day, Year, 3 Sountry) | | | |
| | 10e State | 10b. County | / | | 10d. Inside City Limi | | | | | | |
| Director | CPH. | LANCA | Stell | LANC | caster (| 174 | | | | 1 46s 2 No | |
| | 10e. Street and No. | Elm Au | E . | | | 7602 | | 10g. Citizen of | | try? | |
| by Funeral | | rried 2 Married | 12. Was Decedent Armed Forces? 1 Yes 2 14 if Yes, Give Year or Dates: | | 13. Was Dece If Yes, spe 1 \(\text{Yes} \) | dent of Hispanic Origicity Cuban, Mexican, 2 No Specify: | n? (Specify Yes or N Puerto Rican, etc.) | lo 14. Rad Bla Specif | ce - America ck, White, o | | |
| Completed t | /Sne | 15. Decedent's E | ducetion | 16 | a. Decedent's Usu | al Occupation ork done during most | of working | 16b. Kind of B | usiness/ind | lustry | |
| nple | Elementery/Sec | | Coilege (1-4or 5 | | life. DO NOT u | ise retired) | ~ | H0501 | tal | | |
| | | 2 | 2 | lle | orked in | Admission | s Name (First, Middle | la Maidan Sumar | 201 | | |
| Be | 17. Fathers Neme | (First, Middle, Last | HOOVER | 2 | | // | MAL MAL | 1 | ne) | | |
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| | 19a. Informent's P | Neme/Reletionship (| 1990, PANI) | 15 | Maling Address | s (Street and Number | 1 | City of Town | | | |
| | 20a. Method of Dis | sposition | COVER | 20b. Plece | of Disposition (Na | me of | Date | 20c. Location | City or To | | |
| | 1 Burial 2 | Cremetion 3 | Removal from State | cemet | tery, crematory or | other plece) | 1 ul ho | 11.6 |) , , | | |
| | | 5 Other (Special | | NEW Y | TOYIDEAKE | Churchet Go | 7 4/11/44 | New Me | VIDEL | XE, 174. | |
| | 21. Signature G-F | Operal Service Lice | 1 | | KEUN | nd Address of Facility | Al Home | | 0 | | |
| | Ja | elleys | rolla | | | | | | 1 1- | and the second second | |
| | | ALCOHOL SECTION AND ADDRESS OF THE PARTY OF | | | 014 | 4 E. SALE | J. GUA | CHVILLE, | H. 11 | 266 | |
| | shock of he | the disease, or com art failure. List only | plications that caused one cause on each lin | the death. Do | o not enter the mod | de of dying, such es c | ardiec or respire by | arguilles) | A. // | Approximate Interval Between | |
| | | | plications that caused one cause on each lin | d the death. Do | o not enter the mod | de of dying, such es c | ardiec or respire on | arguille) | 7. // | Approximate | |
| | immediete Cause disease or conditi | (Final | plicetions that ceused one cause on each line | d the death. Do | o not enter the mod | de of dying, such es c | ardiec or respire | orgaille,) | A. 11 | Approximate Interval Between | |
| er | Immediete Cause | (Final | a | Brain | o not enter the mode | july | | | A. // | Approximate Interval Between | |
| miner | immediete Cause disease or conditi resulting in death) | (Final ion | a | Brain Due to (or as a OPE | a consequence of | july | PACTU | PEC | | Approximate Interval Between | |
| examiner | Immediete Cause disease or conditi resulting in death) Sequentially list c | c (Final lon) | a | Brain Due to (or as a OPE | In | july | PACTU | PEC | | Approximate Interval Between | |
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| Certification: To Be Completed by Physician/Medical Examiner | Immediate Cause disease or condition resulting in death) Sequentially list of it eny, leading to it cause. Enter Und Cause (Disease or that initiated even resulting in death) Part II. Other signification of the examiner? 1 | conditions, immediate deriving or injury its Last arred to medical No ath S Pending investigation of Could not be determined. | a | Due to (or as a Due to (or a)))))))))))) | a consequence of) a consequence of) a consequence of) a consequence of) a consequence of) b in the underlying of the und | Cause given in Part I. 26. Place OA Other: 4 Nun 28c. Injury at Work? 1 Yes 2.2. N Ty, office | 23b. Di- 24a. Wa App of Death (Check only sing Home 5 Re 28f. Location City or 7 Rd., J place, end due to th | d tobacco use co | ontributa to 3 Protein formation for the formation of the | approximate representation of the cause of death? The cause of death? | |
| To Be Completed by Physician/Medical | Immediate Cause disease or conditi resulting in death) Sequentially list of eny, leading to it cause. Enter Und Cause (Disease or that initiated even resulting in death) Part II. Other signi | conditions, immediate deriving or injury its Last arred to medical No ath S Pending investigation of Could not be determined. | a | Due to (or as a Due to (or a)))))))))))) | a consequence of) a consequence of) a consequence of) a consequence of) a consequence of) b a consequence of) a consequence of) | Cause given in Part I. 26. Place OA Other: 4 Nun 28c. Injury at Work? 1 Yes 2.2. N Ty, office | 23b. Di- 24a. Wa App of Death (Check only sing Home 5 Re 28f. Location City or 7 Rd., J place, end due to th | d tobacco use co | ontribute to 3 Protein | approximate Interval Between Onset and Death Between Onset and Death Between Onset and Death Between Onset and Death Death Between Onset and Death Death Between Onset and Death Death Pland Onset and Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Onset Death Pland Death | |
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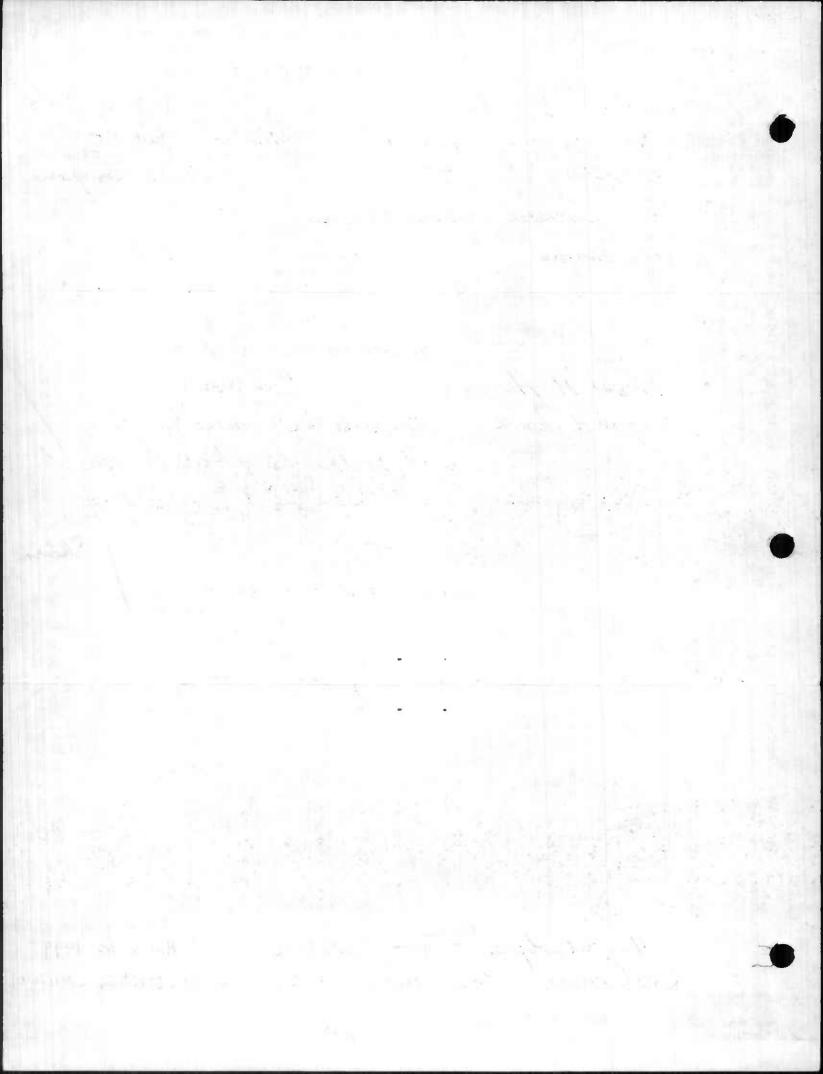
State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 2 1 1999

DHMH 16 Rev 6/95



| CHUNG KING | State of Maryland / Department of Health and Mental Hygiene Gertificate of Death | | | | | | | | | |
|--|---|--|---|--|--|-----------------------------|--|--|--|--|
| K.LING | Decedent's Name (First, Middle, Li | ist) | 00711110410 | | 2. Date of Dec | | 3. Time of Death | | | |
| Physician | Chong Suk Kir | ıg | | | Month APRIL | Day 10, 199 | Year 99 2:10P.M. | | | |
| /Medical Examiner | 4a Facility Nama (If not institution, gir | ve street and number) | | 4b. City, Town, or | Location of Death | | | | | |
| LAdminer | 494 MAIN STREET | | | PRINCE F | REDERICK | CK CALVERT | | | | |
| Funeral Director | | Sex 7. Age (In yrs. 1 | last birthday) If Under 1 Y Yrs. Months Do | | 8. Date of Birt | 1938 | Birthplace (State or Foreign Country) Korea | | | |
| * 3 | Usual Residence of Decedent 10a. Stafe 10b. County _ | 10c Ci | ty, Town or Location | | | | 10d. Inside City Limits | | | |
| vith the Maryla or 28s-f ahor be notified at Director | Maryland Calv | rant | ince Freder | ick | | | 1 ☐ Yes 2 🕍 No | | | |
| | 10e. Street and Number 494 Main Street | et | 101. Zip Co 2067 | | | 10g. Citizen of N United | Mhat Country? 1 States | | | |
| her des | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates: | | of Hispanic Origin? (Cuban, Mexican, Pue No Specify: | Specify Yes or No- rto Rican, etc.) | Blac | e - American Indian, k, White, etc. "Korean | | | |
| 2 hours sale | 15. Decedent's E | ducation | 16a. Decedent's Usual O | ccupation | | 16b. Kind of Br | usiness/Industry | | | |
| 1 21215-0020 ed within 72-hours at yogens returns; or we than 'natural; or it, the Medical Exami Completed by F | (Specify only highest gr Elemantary/Secondary (0-12) 12th | College (1-4or 5+) | homemaker | one during most of wo etired) | rking | own ho | ome | | | |
| | 17. Father's Name (First, Middle, Last |) | | 18. Mother's Na | ma (First, Middle, | Maiden Suman | 00) | | | |
| Via Wient Wient Wite a | Nam-Ki Eun | | | Kwon-I | n Chong | ſ | | | | |
| Maryland alth and Mertial Hy alth and Mertial Hy attraumatic event To Be C | 19a. Informant's Name/Relationship Michael S. Kir | | | Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) Box 206 Prince Frederick, MD 20678 | | | | | | |
| Saltimore, emil. Pages 1 a opartment of Hea montant: if Item my Injury or othe BGB. | 20a. Method of Disposition 1 Durial 2 Tremation 3 [4 Donation 5 Other (Speci | Monitoria in State | Place of Disposition (Name of cometary, crematory or other tropolitan | PplaceApril Funeral | 14 ^{Date} 1999 Service | 20c. Location - | City or Town, State ndria Virgini | | | |
| Balt, Departs Importa any Inja | 21. Signature of Funeral Service Lice | nsee SC | 22. Name and A | R | | | Home PA | | | |
| | 23a. Part1. Enter the disease, or conshock, or heart faiture. List only | plications that caused the dear one cause on each line. | | | | | Approximate Interval Between Onset and Death | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | a. Atheroscle. | ranc Card | brusculas | - dise | ege | unk | | | |
| ovecuted in end interest | Sequentially list conditions, | b. — Dua to (| or as a consequence of): | | | | | | | |
| 8760, rate be executed hysician end the burish-transit dical Examir | if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | G | | | | | | | | |
| | resulting in death) Last | d. | or as a consequence of): | | | | t | | | |
| death cert death cert est for use affor use sician/M | | | | | | | 1 | | | |
| is, P.O. Box es that the death cerl igned by the attendin be detached for use by Physician/N | Part II. Other significant conditions of Diabetes Ma | The state of the s | sulting in the underlying cause | e given in Part I. | Black Charles | robecco use co Yes 2 No | ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown | | | |
| Cord requir been s should | Diabetes Me Hyperhensian | | | | perfo | an autopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? | | | |
| The law ata has page 2 | 0. | | | | 100 | res 2 No | 1 ☐Yes 2 ☐ No | | | |
| Vital Indicate Certificate rector, pag | 25. Was case raferred to medicat | | | 26. Place of De | eath (Check only o | | | | | |
| - x 50 D | axaminer? 1 □XYes 2 □ No | Hospital: 1 Inpatient 2 | ER/Outpatient 3□ DOA | Other | Homa 5 ⊠ Resid | | er (Specify) | | | |
| Vision o Attending Ph or death. ector: After th by the funeral | 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | | Injury at Work? 1 Yes 2 No | 28d. Describe I | now injury occur | red | | | |
| O page | 3 Suicida 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Special | ome, farm, street, factory, of | fice | 28f. Location (S City or Tox | | per or Rural Route Number, | | | |
| he Hospital in 24 hours he Funeral pletely filled edical C | | | | h occurred at the time, data and place, and due to the vestigation, in my opinion, death occurred at the time, | | | | | | |
| To the within 2 To the comple | 29b. Signature and fitle of certifier | ne! | 29c. Li | cense number | | 29d. Date signe | d (Month, Day, Year) | | | |
| - > - 3 |) | 711 | C | C.M.E. | Z | APRIL 11 | , 1999 | | | |

Registrar

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

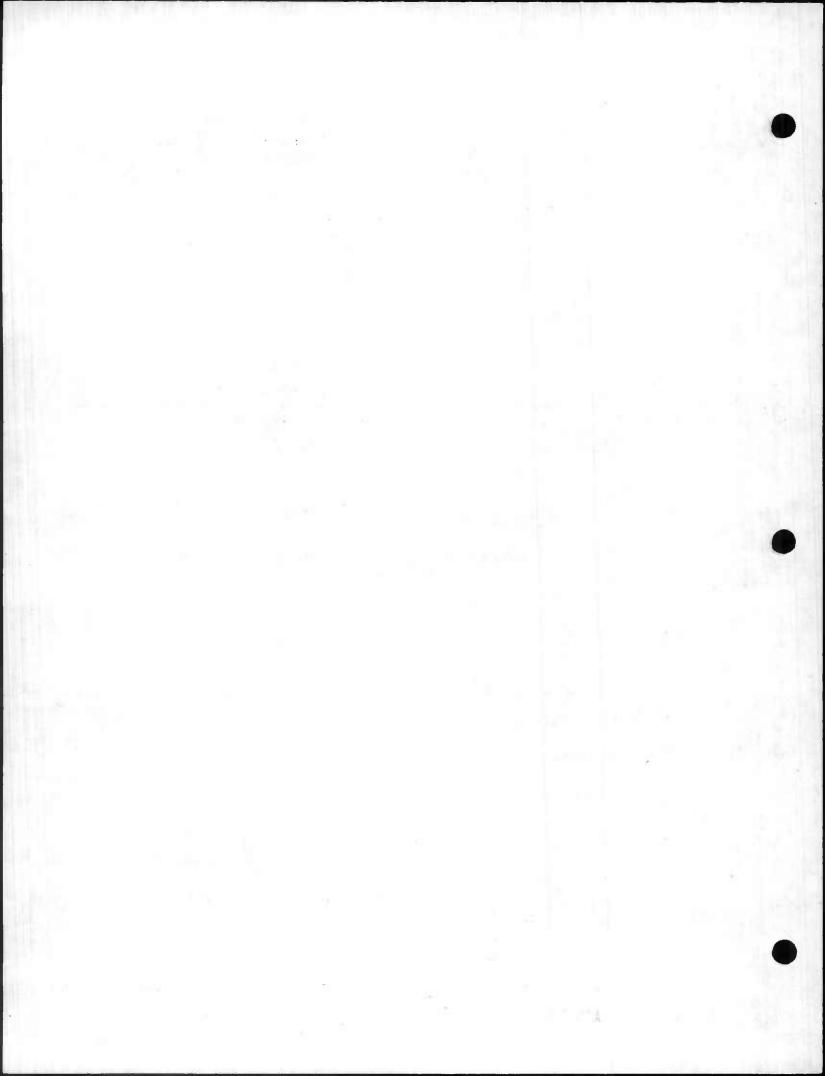
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

R

R

11

32. Registraris Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar Physician H. 11 1999 7:10 PM April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Cecil 241 Melbourne Boulevard 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 □ M 2 🖾 F Months Director May 24, 1924 213-18-4518 74 Virginia Usual Residence of Deceden the Maryland 10d. Inside City Limits 10s. State 10b. County 10c. City. Town or Location must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? fi x "natural", or flams 23a or 241 Melbourne Boulevard 21921 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. "netural", or flar ther then "netural", or flar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Assembly Line Laborer Automobile Manufacturer permit. Pages 1 and 2 should be tiled Department of Health and Mental Hygi Important: If then 27 is marked other any injury or other treumatic event. b 18. Mother's Name (First, Middla, Maiden Sumema) 17. Fathar's Name (First, Middle, Last) 86 Lloyd Vernon McCreary Janette Holdaway 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Gary Lake / Son 88 Caravel Drive, Bear, DE 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State April 13 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 1999 Union Cemetery Elkton, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funaral Service Licendee 127 SOuth Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical WICS Immediate Causa (Final disaase or condition rasulting in death) Elles 117 Examiner Due to (or as a consequence of). Examiner burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Box 68760 certificate be Physician/Medical the Dua to (or as a consequence of): attending 980 0 signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yaa 2 XIO 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen s completion of cause of death? page 2 : has certificate 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? To the Mospital or Attanding P within 24 hours after death.
To the Funeral Director: After it Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicida Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 6 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifie (Check only 296. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and/address of person who-completed cause of death (Item 23a) (Type, Print) 52 6 10 6

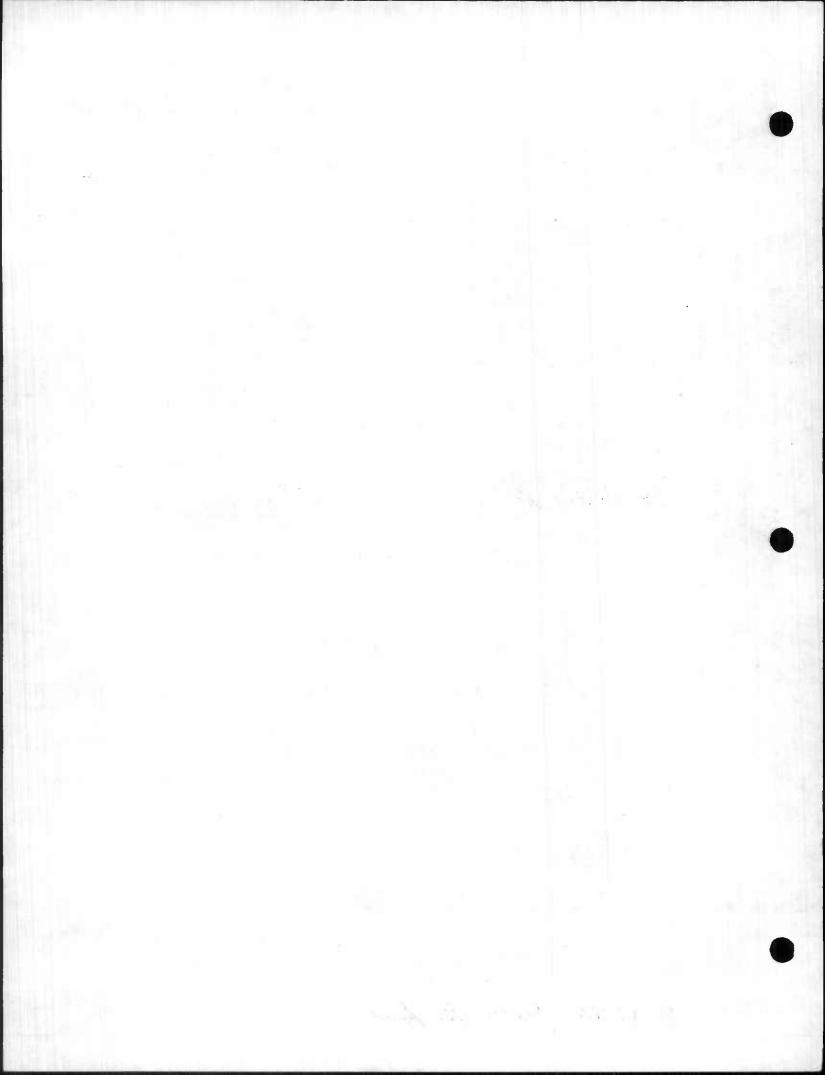
Registrar

State

31. Date filed (Month, Dey, Year)

APR 1 2 1999

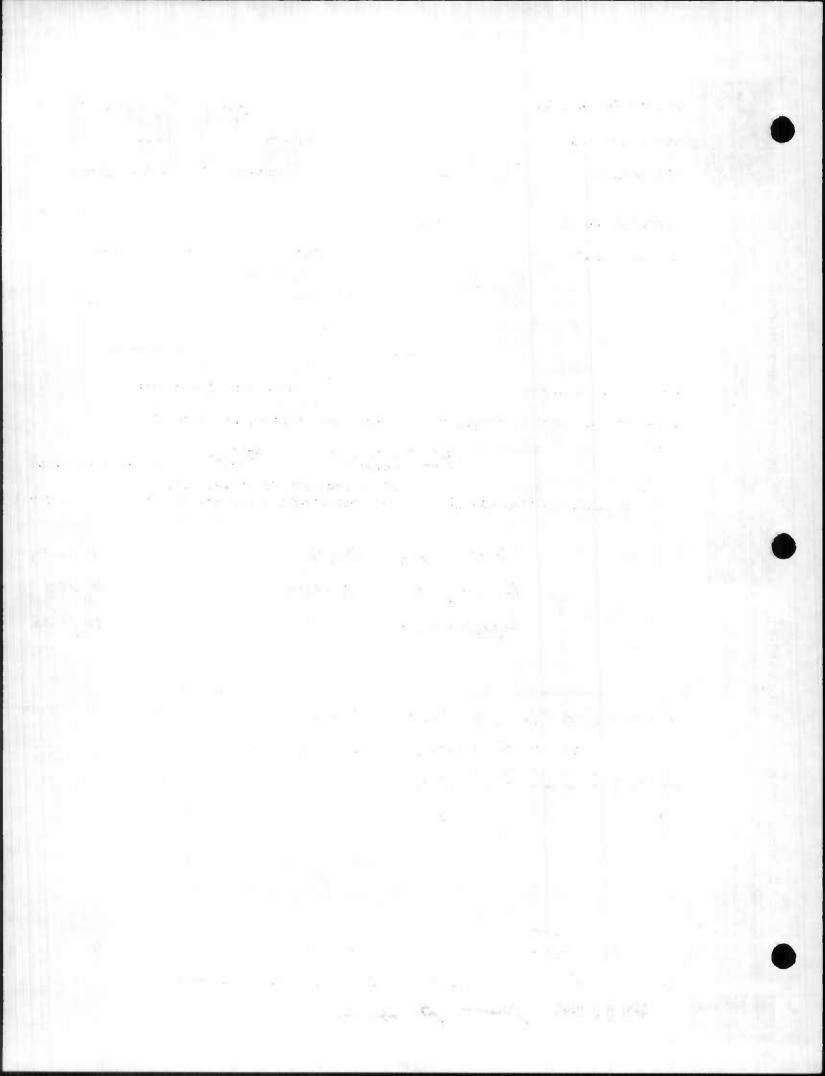
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Q 1990

| | | | | | Ce | rtificate of | Death | F | leg. No. | 10 | 004 |
|---|---|--|--|--------------------|--|---|---|---|------------------------------------|-----------------------|---|
| 100 | | s Nema (First, Midd | le, Last) | | | | | 2. Deta of Dea | th | Year | 3. Time of Death |
| Physicia /Medica | Daisy | Rebecca 1 | Lyle | | | | | April | 6 / | 999 | 1209 |
| Examine | An Panilla Al | eme (If not institutio | n, give street end nun | nber) | | | 4b. City, Town, or I | ocation of Death | 4c. County | of Death | |
| 41 . 1 | | Hospital | | | | | Elkton | | Cecil | | |
| Funeral Director | 212-2 | eurity Number 2-2362 anca of Decedent | 6. Sex 1 □ M 2 □ F | 7. Age (In yrs. 78 | lasi birthday, Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day ember 15 | Year) | Count | eca (Stefe or Foraign lry) and |
| pue * | 10a. Stete | 10b. County | , | 10c. City | y, Town or L | ocation | | | | 10 | Od. Insida City Limits |
| Maryl | 5 | | | | Elkton | | | | | 1 □ Yas 2 No | |
| the the posti | Maryla 10e. Street e | | 1 | E | SIX COII | 10f. Zip Code | 1 | | 10g. Citizen of Whet Country? | | |
| With with | 247 K | irk Road | | | | | 21921 | | United States | | |
| Seath The 2 | 247 K. 11. Marital S | | 12. Was Dece | dant Evar in U, | S. 13. | Wes Decedent of | Hispanic Origin? (Spoan, Maxican, Puerl | pecify Yas or No- | 14. Reca | - America | |
| 21215-0020 d within 72 hours after death with the Maryland giene. rr than "natural", or ferms 23s or 28s-4 ahow the Medical Examiner must be notified. | 3 Da Wide | 1 Never Married 2 Merried 1 Yes, 1 Yes or Yaer or | | | | If Yas, specify Cul | | | Black, White, etc. Specify: Black | | |
| 5-0 72 ho | Elementar | 15. Decedar | nt's Education est grade completed) | | 16e. Dece | dent's Usual Occu | pation during most of wor | kina | 18b. Kind of Bu | siness/Ind | ustry |
| vithin within the Mon | Elementar | y/Secondary (0-12) | College (1 | -4or 5+) | | DO NOT use retire | during most of worded) | | | | |
| d 2121 filed within Hygiene. other than | Ö | 8 | | | Cook | | | | Restau | | |
| be fill H doth | m l | Nama (First, Middla, | Last) | | | 18. Mother's Neme (First, Middle, Meiden Su | | | | | |
| larylan | | es Cecil | | | T | | | hine Ric | | 0 7: | 0.41 |
| Maryland d 2 should be file th end Mental Hy 7 is marked oth traumatic avam | | nt's Name/Relations | | | | | etend Number or Ru d, Elkton | | | | Code) |
| Te, N 1 end 1 Health Health | | of Disposition | assidy/ Da | | | osition (Nema of | a, EIRCOII | Date | 20c. Location - | | um State |
| Baltimore, Maryland 21215-0020 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, the Weden Examine must be notified once. | 1 ⊠ Buri 4 □ Don | | | State Gri | emetery, cre iffith irch C 2 H | A.U.M.P A.U.M.P emetery 2. Name end Addi icks Hom | ess of Fecility | pril 10, 1999 erals, P | Cedar H | i11, | Maryland |
| | 23a Parti | 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. | | | | | | | | | Approximate |
| Street day | shock, | or heert feilure. List | only one cause on e | ech line. | n. Co not on | to the mode of dy | ing, such as cardiac | or respiratory an | | | Interval Between Onsat and Death |
| Physician /Medical | Immediate C | Ceuse (Finel | 6 | 11 | 1.1 | · A. | V | | | | an Martan |
| Examiner | disease or c | ondition | e. 30 | | | ic Den | 7n | | | | 30 Mintes |
| | 6 | | 12- | | r es e conse | | 2162 | | | | 1110416 |
| bear Insit | Ē | | b. Carl | NAMY | r es e conse | my DIS | ease | | | - 1 | gener |
| exect n end iel-tra | Sequentially if any, leading | list conditions, ig to immadiate ir Underlying asa or injury | | Due to (o | r es e conse | querica oi). | | | | - | DUDAAC |
| 68760, ficate be executed physician end is the buriel-transit. | Sequentially if any, leadir cause. Ente Cause (Dise that Initiated rasulting in co | events | c. Hype | Due to (or | r as a conse | quence of): | | | | - | D years |
| certifica ding pl | Ž. | | d | | | | | | | | |
| Box eath cert ettendin for use | i i | | | | | | | 1 | | | |
| P.O. thet the ded by the detached | Pert II. Other | significant condition | ons contributing to de | ath but not rase | ulting In the u | underlying cause g | iven in Pert I. | | | | the cause of death? |
| IS, P. (es thet the igned by be detac | DIABET | tes Mellitus | S Type I, | END ST. | rge R | eNAL FA | ilune | 101 | (ee 2) No | 3 Proc | ably 4 Unknown |
| Records, P.O. Box 68760, ne law requires that the death certificate be executed a has been signed by the ettending physician end age 2 should be detached for use as the buriel-transit | Pert II. Other DIASET ANEMIN LEUKO | 4 AF EUD | STAGE REA | VAL FAI | lune | Chrow | c Lyzohai | 24a. Was a perfor | an autopsy med? | eve | ore autopsy findings sileble prior to npletion of cause death? |
| I Rec | E /- //- | / 64 | WICAL DIAGN | wais | , , | 1 | | 1 D Y | es 2X No | | Yes 2□ No |
| Vital Rician: The certificate rector, pag | | e referred to medical | yph NODE 10 | signsy 12 | Nains | } | 26 Pleas of Day | eth (Check only o | | | 7100 20110 |
| | 20 exemine | ? 2□ No | Hospital: | npatiant 2 | ER/Outpetie | nt 3 DOA | ther | lome 5 ☐ Resid | | ar /Snecih | (1 |
| Phys rthis aral di | | | | of Injury | 28b. Time o | | | | ow injury occurr | | , |
| on ding | 2 Acci | | | h, Dey Yaer) | Injury | | ork? ∃Yes 2⊟No | | | | |
| Vision Attending or death. ector: After by the fune | 3 ☐ Suid | ide 6 Could | nined 288. Piece | of Injury - At he | ome, ferm, st | reet, factory, office | • | | treet end Numbe | er or Rura | I Roufe Number, |
| Division or Attending efter death. Director: After d in by the fune | 4 Hom | nicide | buildir | ng, etc. (Specify | y) | | | City or Tow | m, Stete) | | |
| | 29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and ma (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and menner stated. | | | | | | | | nner as st and due to | ated. the cause(s) | |
| o the | | re end title of certifie | ir 🦳 | | | 29c. Licar | nse number | | 29d. Data signed | d (Month, i | Day, Year) |
| F > F 0 | 1 | 1/1 | Second No. | | | 4 3 | 7636 | | 04-06 | -90 | 3 |
| K | 30. Name en | d eddress of nerson | who completed cause | e of death (Item | 23e) (Tvne | | 000 | | 0,00 | | |
| | MAST | - 1 | AVIN D | A940 | | | NEWARK | DE 19 | 713 | | |
| Stat | 31. Date filed | (Month, Day, Year) | 82. Re | egistrer's Signa | | 1 | 1001011101 | , , , | 1 1 | | |
| Registra | // | PR 0 9 199 | 39 300 | , was | Ø. | sporks | | | | | |

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 09 1999 Vernon Thomas Miller /Medical 4c. County of Dee 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In vrs. lest birthdev) Birthplece (State or Foreign Country) **Funeral** 18 M 2□ F 221-03-3228 82 Director September 5, 1916 Maryland Usual Residence of Deceden with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10e Stete 10b County "natural", or items 23s or 28s-f show 1 ¥Yes 2 □ No Director Cecil Elkton Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code United States 21921 216 West High Street Funeral Peges 1 end 2 should be filed within 72 hours after deeth nent of Health end Mental Hygiene. nt: If Item 27 is marked other then "natural", or Items 23: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWI I Rece - American Indien, Bleck, White, etc. 11 Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by WWIT White 3 Widowed 4 Divorced Completed 7 is marked other than "natur treumatic event, the Medical 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Truck driver 11 Transportation 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Margaret Krauss Thomas Roy Miller 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) 276 Russell Road, Elkton, Maryland Gail E. Milburn/ Daughter If Item 27 or other t 20b. Plece of Disposition (Name of cometery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition April 13. 1 Buriel 2 □ Cremetion 3 □ Removel from State Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Union, Maryland Union Cemetery 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 eles 220 1 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examine Examiner conce Che physician end s the bunal-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Hea (pue to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? should 24a. Wes en autopsy Completed ils certificate hes t director, pege 2 s The 1 Yes 2 LM 1 □ Yes 2 □ No Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 1 Impatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel To the Hospital or Atlandir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 P Homicide 1 determination Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

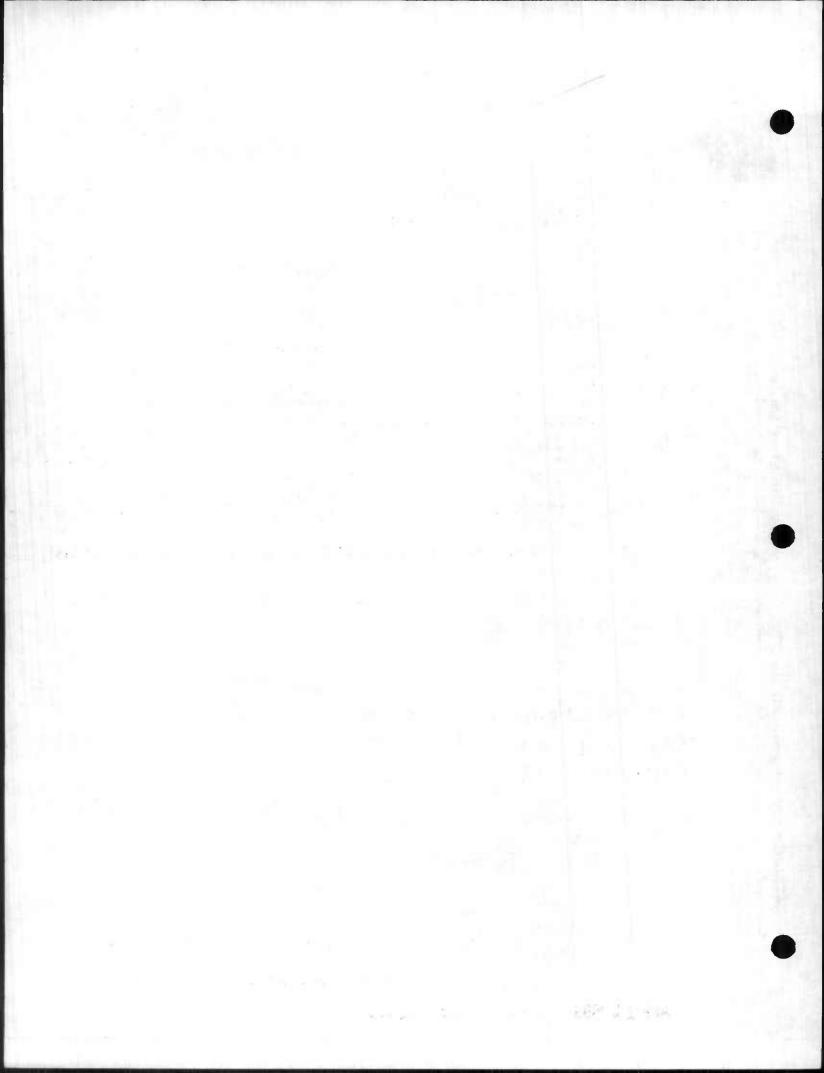
2 Medical Examination: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 290. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number entilal.10 22307 30. Nem and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ELICTORY MD 21921-123 Singerl HVe, 32. Registrer's Signature 31. Dete filed (Month, Day, Year) APR 1 3 1999 Registrar

DHMH 16 Ray 6/95

924 83 8W

State of Maryland / Department of Health and Mental Hygiene 9 9 1 9 3 0 6

| | | | Ce | rtificate of | f Death | R | eg. No. | 1 | 000 | |
|---|--|---|-----------------------------|--------------------------------------|--------------------------|---|-----------------------------|-------------|--|------------|
| | 1. Decedent's Name (First, Middle, Last) | 2. Date of Dea Month | th Day | Year | 3. Time of | Death | | | | |
| Physician /Medical | GEORGE M. MONT | GOMERY | | | | April | | 1999 | 0025 | AM |
| Examiner | 4a Facility Name (If not institution, give s | treet end number) | | | 4b. City, Town | , or Location of Death | 4c. County | of Death | | |
| <u> </u> | Sunrise Healthcare | & Rehabilita | ation | | E1kt | | Ce | ecil | | |
| Funeral | 5. Social Security Number 6. Sex | M 2DE | | Months Day | | Min. (Month, Day | Year) | Coun | lace (State or | r Foreign |
| Director | 234-40-6730 | 72 | Yrs. | | | April | 7, 1927 | Vir | ginia | |
| Pu | Usual Residence of Decedent 10a. State 10b. County | 10c City | , Town or Lo | ncation | | | | 1 | Od. tnside Cit | tv 1 imits |
| atho atho | | | | | | | | | TX Yes | |
| or 28s-fs be notified | Maryland Cecil 10e. Street and Number | | E1kton | 10f. Zip Code | | | 0g. Citizen of V | What Cours | 10.0 | |
| death with the Maryland ms 23s or 28s-f show constitute to notified at | | | | | | | | | | |
| r tems 234 | 1 Price Drive | 2. Was Decedent Ever in U.: | S 13 | | L921 | ? (Specify Ves or No- | United | a - America | | |
| Tun Per o | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☒ No | . , | If Yes, specify Cu | ban, Mexican, P | ? (Specify Yes or No- uerto Rican, etc.) | Blec | k, White, | etc. | |
| 0 0 0 | 3 ☐ Widowed 4 ☒ Divorced | If Yes, Give Year or Dates: | 100 | 1 ☐ Yes 2 ☑ No | Specify: | | Specify | . Whi | te | |
| 72 hours from the state of the | 15. Decedent's Educ | ation | 16a. Dece | dent's Usuat Occ | upation | | 16b. Kind of Bu | siness/Inc | Justry | |
| Adryliana Z 1 Z 13-0020 2 should be filed within 72 hours after and Mental hygiene. Is marked other than 'natural', or its surratic event, ins the 'natural' or its To Be Completed by Fu | (Specify only highest grede Elementery/Secondary (0-12) | College (1-4or 5+) | (Give | kind of work don DO NOT use retir | e during most of red) | working | | | 100 | |
| d with | 12 | College (1-401 5+) | Main | tenance | Departm | nent | State H | lighw | ay Dep | art. |
| Be C | 17. Fether's Name (First, Middle, Last) | | | | 18. Mother's | Name (First, Middle, | Maiden Sumam | e) | | |
| ylar Menta M | James Garfield Mon | ntgomery | | | Roset | te Phillip | s | | | |
| Maryland 42 should be file th and Mental Hy 7 is marked othe traumatic event | 19a, Intorment's Name/Reletionship (Typ | e, Print) | 19b. Maili | ng Address (Stree | et and Number o | or Rural Route Number | , City or Town, | Stete, Zip | Code) | |
| alth alth | Lisa Gallaher / Da | aughter | 13 AJ | S Court | , Elktor | , MD 2192 | 21 | | | |
| Baltimore, Maryland 212 permit. Peges 1 and 2 should be filed within Department of Haalth and Mental Hygiene. Important: if then 27 is merked other than any injury or other traumatic event, in a pice. To Be Compi | 20a. Method of Disposition | | | osition (Name of metory or other p | lace) | April 13 | 20c. Location - | City or To | wn, State | |
| Saltimore, semir. Peges 1 at separtment of Haa mportant: if Nem inty Injury or other interes. | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | mover from State | | metery | | | Elkton, | Mary | land | |
| Dealt. Department imports any inju | 21. Signature of Funeral Servicert Consu | 4 44 | 22 | 2. Name and Add | | | | | | |
| n asers | 11/18/11 | 12 | | ouch Fur | | ome reet, Nort | h Foot | MD | 21901 | |
| | 23a. Pert1. Enter the disease, or complic shock, or heart teilure. List only one | ations that caused the deeth | | | | | | , III | Approximate Interval Bety | 9 |
| /Medical Examiner | Immediate Cause (Finel disease or condition resulting in death) a. | CHRONIC OF Due to (or | BSTR es a consec | | PULIV | 10nary | diseas | 7 | yeans | |
| cate be executed physician end s the burial-transit | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c. | Due to (or | as a consec | a consequence of): | | | | | | |
| Z and | that initiated events resulting In death) Last | | | | | | | | | |
| death death e atten | Part II. Other significant conditions conti | ributing to death but not resu | Iting in the u | nderiving cause o | oiven in Part I. | 23b. Did to | obacco use cor | ntributa to | the cause o | of death? |
| as that the deligned by the a deteched for by Physic | End Stace Ren | | | | | 1 U Y | ea 2 10 No | 3 ☐ Prot | bebly 4 🗆 (| Unknowr |
| seen s hould | Cononary An | tery dis | eas | - | | 24e. Was a perfor | | COI | ere autopsy ti aileble prior to mpletion of co death? | 0 |
| sician: The law certificate has birector, page 2 s | Diabetes 1 | MELLI | TU | S | | 1 🗆 Y | | | Yes 2 | No |
| yelclen: The yelclen: The sector, per director, per To Be Co | 25. Was case reterred to medical axaminer? | espital: | | | Whore | Death (Check only or | | | | |
| - > 500 | 1 Yes 2 No | 1 Inpatient 2 1 | ER/Outpatier 28b. Tima o | NE BLI DOA | 4 LSPAULSI | ng Home 5 Resid | | | γ) | |
| After fune | 1 ☐ Natural 5 ☐ Pending investigation | 28a. Date of Injury (Month, Dey Year) | Injury | W | ork? □ Yes 2 □ No | | ow injury occur | 60 | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: 7 | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At ho building, etc. (Specify | me, tarm, str | reet, tactory, offic | е | 28t. Location (S City or Tow | treet and Numb n, Stete) | er or Rure | l Route Num | ber, |
| n 24 hours n 24 hours ne Funer pletaly fill | | clan: To the best of my know er: On the basis of examineti and manner stated. | | | | | | | |) |
| Withir Comp | 29b. Signature and title of cartiflor 29c. License number 29d. Date signed (Month, Dey, Year) | | | | | | | | | |
| | > NIMI S. him | cr ws | | D | 00530 | 034 | 4 12 | 99 | | |
| | 30. Name and address of person who con | pleted cause of deeth (Item | 23a) (Type, | Print) 315 W | MAIN | ST E | LIC TO | NA | no e | 192/ |
| State | 31. Dete filed (Month, Day, Year) | 32. Registrer's Signat | ure / | | | | | | | |



State Registrar

DHMH 16 Rev 6/95

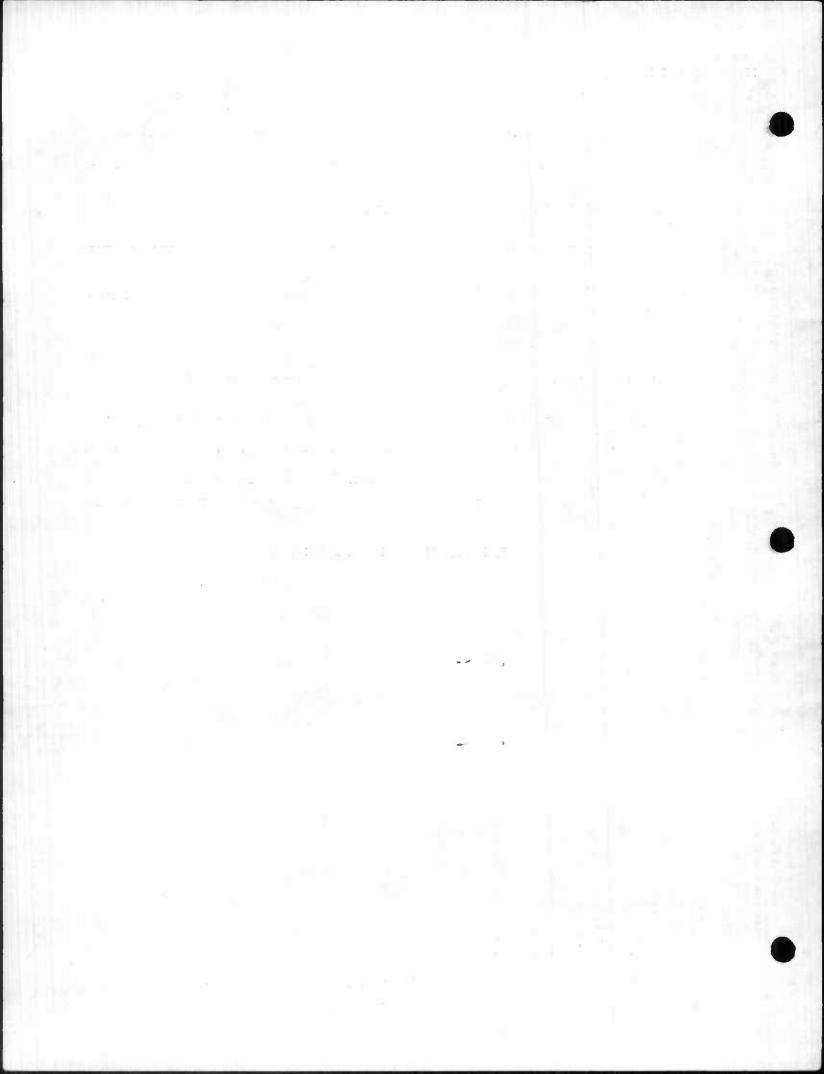
31. Dete filed (Month, Dey, Year) APR 22

Nama end address of person who compl

4DM ATS

Royaum 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** HARVENE ONIZUK April 1999 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ECK to N

If Under 24 Hrs. 8. Data of Birth
(Month, Dey, Yeer)
(Month, Dey, Yeer) HOSPITAL UNION CECIL If Under 1 Yaar 6. Sax 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Monihs Deys 1 M 2 F 214-20-875 Usuel Residence of Decedent Yrs. YEADON PA Director 10d. Inside City Limits 10s State 10c City Town or Location 10h County traumatic event, the Medical Examiner must be notified at 1 Yes 2 No CECIL Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2 / 9 2 / 13. Was Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. items 23s HILL KOAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Meritel Status permit. Pages 1 and 2 should be filed within 72 hours efter or Department of Heelth end Mental thygiene. Important: If Item 27 ia marked other than "natural", or iter 1 Never Marriad 2 Married 1□ Yes 20 No Baltimore, Maryland 21215-0020 Specify: by WHITE 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grede completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Home tousewiFe 12 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fajhar's Neme (First, Middle, Last) HOLLETT HAIVEY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 20b. Plece of Disposition (Name of cemetary, crametory or other plece) ROAD SAMUEL ONIZUK - SON ELKTON MD. 21921 other t 20e. Method of Disposition 20c. Location - City or Town, Stete Data 1 □ Burial 2 □ Cremetion 3 □ Removel from Stete any injury or Wichester PA 4 ☐ Donation 5 ☐ Other (Specify) FERTIS TNC 22. Nama and Addrass of Fecility 21. Signatura of Funarel Sarvice Ligarian 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only on cause on each line. Approximata Intarval Batween Onset end Deett **Physician** /Medical Immediate Ceusa (Finel diseese or condition rasulting in death) week Examiner Examiner CHTONIC pulmonary Lears Obstructive physician end the burial-tran-Sequentially list conditions, if eny, leeding to immediate causa. Entar Undarlying Couse (Diseese or Injury that initiated events rasulting in daeth) Lest Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acute Myocardial InFarction Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy Completed Acute Rend 1 Yes 2 No 1 □ Yas 2 □ No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical funeral director. Be 25. Wes case raferrad to medical 26. Place of Deeth (Check only one) axaminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28e. Dete of Injury (Month, Dey Yaar) 28c. Injury ef Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated. 29a. Cartifier Medical To the Within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signefure end fille of certifier 29c. Licansa number Monte Maleons, 0-44783 April 12,1999 7 30. Neme end address of person who completed causa of daeth (item 23e) (Type, Print) ELKTON, MO MONTE MAKOUS, MO West High Street 21921 111 31. Date filed (Month, Dey, Yeer) APR 1 3 1999 32. Registrer's Signature State Registrar

the terms of the section of the sect

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth April Day **Physician** 5, 1999 FRANCES LOUISE PIPPIN 4:50pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EIRTUNE 8. Date of Birth (Month, Day, Tune 8 Ceci1 Union Hospital 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1924 Months 10 M 20 F Maryland 218-16-7301 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f above ofices Examiner must be notified at MD Cecil Cecilton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Meniel Hydiene. Important: If item 27 is marked other than "natural", or items 234 any Injury or other treumatic event, in a Healtes Examine mentals. 21913 410 Crystal Beach Rd. U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 10 Baitimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) 8 Ralph Schuyler Mary Nash 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) (husband) William Pippin 410 Crystal Beach Rd. Cecilton, MD. 21913 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 4/10/99 Zion Cemetery Cecilton, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Galena Funeral Home of Stephen Schaech M00510 118 W. Cross St. Galena, 21635 MD. 23a Pertive the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): 68760 cnc (0 mey Physician/Medical Dua to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 a hes 1 ☐ Yes 2 No 1 ☐ Yes 2M No of Vital 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Shie funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending Division 1 SNatural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tolal.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 123 Singerly Ave. Elkton, MD. 21921 Jayantilal K. Patel MD

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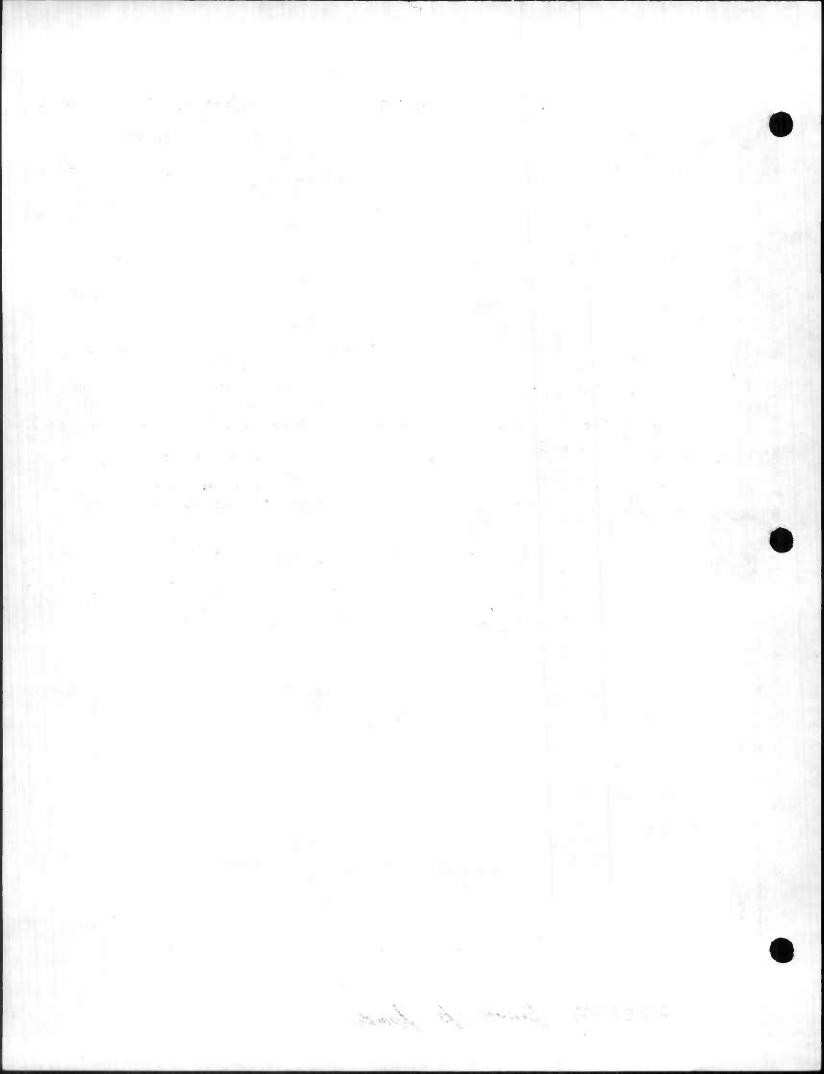
State

Registrar

31. Data filed (Month, Day, Year)

APR 0 8 1999

32. Registrar's Signature

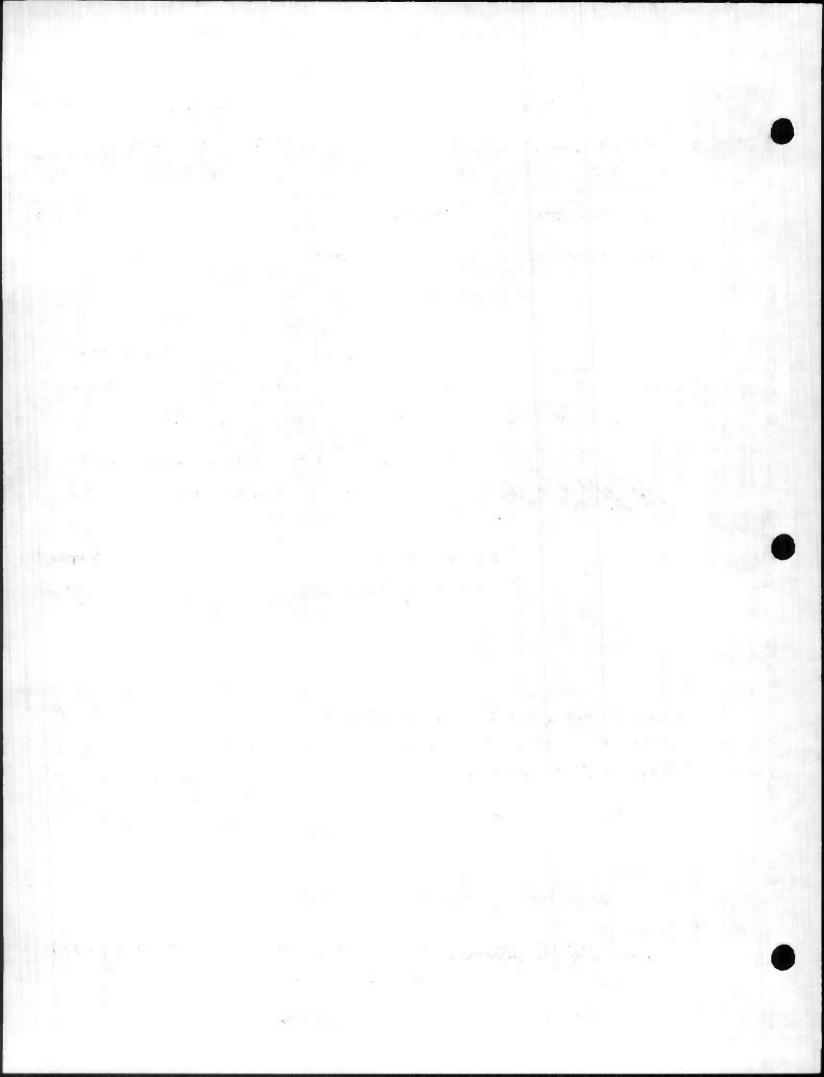


State of Maryland / Department of Health and Mental Hygiene Q

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| - 1 | J | 7 | - 1 | U |

| | | | | | | Certificate | e of L | Death | | Reg. No. | 1 | 0010 |
|------------|--|--|---------------------|--|---|--------------------------------------|------------------|---|---------------------------------------|---------------------------------|----------------------------------|--|
| | | 1. Decedeni's Nema (| | | | | | | 2. Data of De | | Year | 3. Time of Deeth |
| | Physician /Medical | CHARLES | L. | EROY | | PULEO | | | APR I | L 9, 19 | 999 | 0626 am |
| | Examiner | 4e Fecility Name (If n | ot institution, giv | street and numbe | r) | | 4 | b. City, Town, or | Location of Deal | h 4c. County | of Deeth | |
| | | Calver | t Memor | ial Hospi | | | | rince Fr | | | | |
| L | Funeral Director | 5. Social Security Num 577 20 02 Usual Residence of Di | 30 | | Age (In yrs. last birti | Months Months | Deys | If Under 24 Hrs Hours Min. | 8. Dale of Bi (Month, Do July 1 | ey, Year) | 9. Birthp Coun Was | placa (Stete or Foreign htty) Sh., DC |
| | pue m | 10a. Stele 1 | 0b. County | | 10c. City, Town | or Location | | | | | 1 | 0d. Insida City Limits |
| | vith the Merylan is or 28a-f ahow be nourised at | MD A | nne Aru | ndel | Rose I | laven | 0-4- | | | 10g. Citizen of V | Affact Cour | 1 ☐ Yas 2 📉 No |
| | | 10e. Street end Numb | | | | | 2071 | | | USA | | |
| 21215-0020 | urs after ar, or its marring by Fui | 3 ☐ Widowed 4 | | 12. Was Decedar Armed Forces 1 [28/es 2 [If Yes, Give Year or Delas | s? 1942–45 | 13. Was Deced | | ispanic Origin? (S n, Mexican, Puerl Specify: | pecify Yes or No to Rican, etc.) | Bled | e Amand ok, White, www.whi | |
| 5-0 | ed within 72 hours ygiene. ner then "natural", rt, rva Madical Ex | (Specity | 5. Decedent's Ed | | 16e. | Decedent's Usue (Give kind of wor | ol Occupe | etion during most of wo | rking | 16b. Kind of Bu | siness/îne | dustry |
| 121 | d within giene. | Elementery/Second | | College (1-4o | r 5+) | | | | | Commit | | |
| 7 | offied vent, the | 8 17. Father's Neme (Fi | ret Middle I ast | | | Steamfi | rrer | | me /First. Middle | Const | | .10n |
| an | nould be fill if Mental Harked out | Tomanh | A | | Puleo | | | Elvira | | | | afulli |
| Maryland | 2 st end le m | 19e. Informant's Nam Ellen M. | | | | | | end Number or Ri North Be | | | | |
| | f Health fam 27 I | 20a. Method of Dispos | | | 20b. Place of | Disposition (Nan cremetory or o | na of | 1 | Dete | 20c. Location - | City or To | own, Stete |
| imo | 0 E = > | 1 🕅 Buriel 2 □ 0 4 □ Donetion 5 | | Removal from Stat () | a | erans C | | | 1-15-99 | Chelter | nham, | MD |
| Baltimore, | permit. Peges 1 end Department of Health Important: If Itam 27 any injury or other ti ange. | 21. Signature of Pune | rai Spreto Liper | soo pk | 2 | 22. Name en Rausc | | ss of Facility Ineral Ho | ome, Ow | nings, M | 20 | 736 |
| r | | Part1. Entar the shock, or heert f | diseese, or com | olicetions that caus | ed the deeth. Do n | ol enter the mod | e of dyin | g, such es cardie | c or respiretory | irrest, | 1 | Approximate |
| | Physician | SHOCK, OF HEER I | ellure. List only | one cause on eech | iirie. | | | | | | 1 | Onset end Deeth |
| | /Medical | Immediate Cause (Fir disaase or condition | nel | Mes | othelio | ma | | | | | | 3 months |
| | Examiner | resulting in deeth) | | 0. | Due to (or es a c | | | | | | | 3 |
| - | P # E | | | Puln | wary | Ashe | stu | 212 | | | 1 | years |
| | executed n and ial-transit | Sequentially list condi | itions, adiate | | Due to (or es a-c | onsequence of): | | | | | | 9 |
| 68760, | nysicia he bur | | | С | Due to (or es e c | onsequence of): | | | | | | |
| Box 6 | ng p | 1 | L | d | | | | | | | 1 | |
| _• | thet the death condeted by the ettend deteched for us | Pert II. Other significa | int conditions c | ontributing to death | but not rasulting in | the underlying c | ause giv | en In Pert I. | 23b. Did | tobacco use co | ntribute t | o the cause of death? |
| P.0 | thet the ed by the deteche | Chreme | Obstru | - other Pu | Imonar | Dire | 43.0 | | 10 | Yes 2□ No | 3 Pro | bably Wunknow |
| Records, | The law requires that the death ce tale has been signed by the ettending page 2 should be deteched for us. | Chronic | schero | He Can | elova | cular | 1 | DHEW | 24a. Wa | s an autopsy ormed? | ev | fere autopsy findings reilable prior to empletion of cause |
| | The law rate has be pege 2 st | Atrial | | uythm! | | | | | 10 | Yes 2000 | of | deeth? |
| of Vital | certificate rector, peg | 25. Wes case referred | to medical | | | | | 26. Place of De | eth (Check only | | | |
| † | Physician: this certific ral director, | exeminer? | | Hospitel: | tienI 2 ER/Out | petient 3 DC | Oth Oth | er: 4 Nursing I | Homa 5□Res | Idence 8 Oth | er (Specil | ty) |
| 0 | ding Phys h. Atter this funeral di | 27. Menner of Deeth | 5 Pending | 28e. Dete of Ir (Month, I | jury 28b. T | ime of 2 | 8c. Injun Wor | y et k? | 28d. Describe | how Injury occur | red | |
| Sio | Attanding or deeth. actor: After by the fune | 2 Accident | investigation | 1 | | М | | Yes 2□No | | | | |
| Division | tel or Attanding P is efter deeth. The Director: After the fine is by the funers Certification: | 3 ☐ Sulcide 4 ☐ Homicide | determined | 28e. Pieca of | Injury - At home, fer etc. (Specify) | m, street, factory | y, office | | 28f. Location City or To | (Street end Numb own, State) | er or Run | al Routa Number, |
| | pital purs prairied filled | 29a. Certifier 1 | G Caribina Dh | velsion. To the her | st of my knowledge, | dooth populated | at the tim | no data and place | and due to the | cause(s) and m | 200001 80 1 | teted |
| | ne Hospi n 24 hou ne Funer pletely fill edical | (Check only 2 | | | of examination end | | | | | | | |
| | To the Hospital or Attandit within 24 hours effer death. To the Funeral Director; A completely filled in by the ti | | e of certifier | | | 290 | c. Licans | a number | | 29d. Date signe | d (Month, | Day, Year) |
| | | 1 /000 | 100 9 | Ster | me- M | D. | 1 | 1245 | | April | 9. | 1999 |
| | 15 | 30. Name and eddress | | | | | | | | 4 | | |
| | 1 VA | Dr. Gera | | erner, M | I.D. Ow | ings, | Mar | yland | 20736 | | | |
| | State Registrar | 31. Dete filed (Month, | APR 1 | | strer's Signatura | 6. | 20 | arka | | | | |

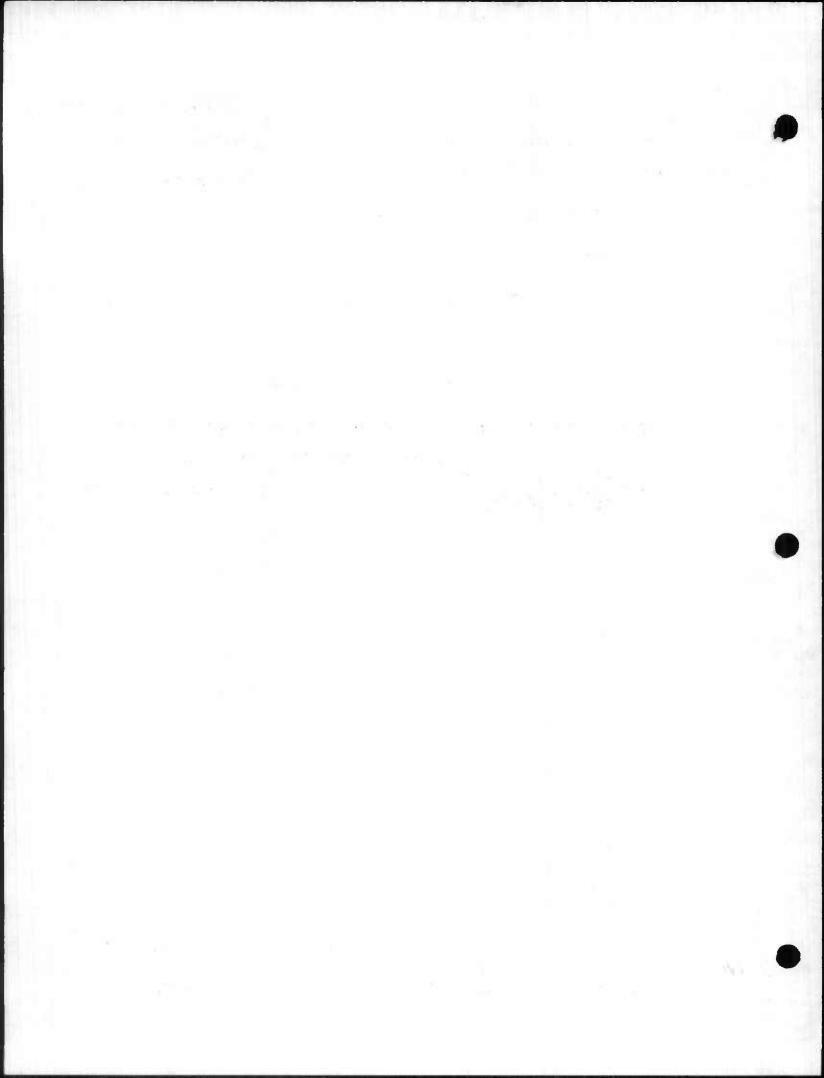
DHMH 16 Rev 6/95



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|--|---|----------------|---|--|---|---|-------------------------------------|---|--|--|-------------------------------|------------------------------------|---|
| | W. S. W. | 201 | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of D | eeth | | | 3. Time of Death |
| | Physici /Media | | William | PHILLIPS | | | | | April | 6, D | 1 999 | Year | 4:15 pm |
| 1 | Examir | | 4a. Facility Neme (If not institution, give s Charlotte Hall Ve | | | | | | Location of Dee e Hall | The state of the s | | | |
| | Funeral Director | | 5. Social Security Number 8. Sex 191 18 0053 | 7. Age (in yrs. ii | | day) If Under 1 Months C | | Jnder 24 Hr ours Min | | ay, Yea | | 9. Birthpiad Country | ce (Stata or Foreign |
| | n the Maryland r 28a-f ehow | ctor | 10a. State 10b. County St. Mary | 's 10c. City | , Town narl | or Location otte Hal | 1 | | | | 10d | . Inside City Limits 1 ☐ Yes 2☐ No | |
| | fier death with the r fterms 23e or 28 iner must be no | rai Director | 10a. Street and Number Rte. 2, Box 5 | | | 10f. Zip Co | ode 20622 | 2 | | 10g. Citizen of Whet C | | | 7 |
| 020 | 0 0 5 | by Funeral | 11. Maritel Stetus 1 □ Never Married 2 □ Merried 3 □ Merried 4 □ Divorced | 2. Was Decedent Ever in U, Armed Forces? 1 Des 2 No If Yes, Give Year or Dates: 1943 | | 13. Wes Deceden If Yes, specify | | nic Origin? (exican, Pue pecify: | Specify Yes or N nto Rican, etc.) | 0- | e - American k, White, etc |). | |
| 1215-0020 within 72 hours of me. then "natural", or | ithin 72 hours he. hen "netural", h. Medical Ext | Completed | 15. Decedent's Educ (Specify only highast grade Etementary/Secondary (0-12) | ation complated) College (1-4or 5+) | (| Decedent's Usual C Giva kind of work of ifa. DO NOT usa | occupation dona dunin atired) | g most of we | orking | | usiness/Indus | | |
| 7 | ygier ygier rt, fr | ဝိ | | 2 | lesman | | | | | ne too | ots | | |
| yland | Mentel H Mentel H arked oth | To Be | 17. Fether's Name (First, Middle, Last) William | Phill | 18. Mother's Nam unknow | | | | a, Maida | n <i>Sum</i> am | ia) | | |
| Jar | 2 Style | | 19a. Informant's Neme/Relationship (Typ | | | Mailing Address (S | | | | - | | | ode) |
| e, | leath m 27 ther tr | | Mary T. Phillips 20a. Method of Disposition | | _ | 7 Adelph Disposition (Name | - | , Hya | Date | 1 | | 0782 | 01-1- |
| Saitimor | nit. Pages artment of a ortant: If the injury or of th. | l li | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State Me | m etary, | crematory or othe colitan C | r place) | cory | 4-8-99 | | | city or Town | |
| pai | Depart Depart Import any in | | 21. Signature of Fuperal Service Operas | 1 Phia | | 22. Neme end A Rausch | Funei | cal Ho | | | , MD | 2073 | 36 |
| | | | Part1. Enter the disease, or complice shock, or heart failure. List only on | cetions that caused the death e cause on each line. | . Do no | t enter the mode o | f dying, su | ich as cardia | c or respiratory | arrest, | | le le | pproximate itervat Between Inset and Death |
| | Physician /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in death) a | ASPIR | ATI | ON | | | | | | FE | See Hinney |
| | | er | | Due to (or | as a co | ensequenca of): | | | | | | 1 | |
| | ate be executed hysician and the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | DUSPHAGIA Due to (or as a consequenca of): | | | | | | | | YRS |
| BOX 68/6U, | death certificate be executed e attending physician and od for use es the burial-transit | edical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or | nsequence of): | | | | | | | | |
| _ | d for u | Iclar | Pert II. Other algnificant conditions con- | ributing to death but not resu | ting in t | ha undarhina caus | e circo lo | Dart i | 22h Die | Ltobacc | 0 1100 000 | ntribute to th | he cause of death? |
| 7. | v requires that the de been signed by the a should be detached | by Physician/M | CHRONIC OBSTRU | | | | | T GIL I. | | | 2 No | 3 Probal | |
| ecords, | lew require es been sig 2 should b | Completed t | | | | | | | 24a. Wa | s an eut formed? | opsy | availe | autopsy findings able prior to pletion of cause ath? |
| = | Physician: The lev this certificate hes ral director, page 2 | Con | | | | | | | 1 🗆 | Yes | 2.X) No | 101 | res 2□ No |
| VII | Physician: this certific ral director, | Be | 25. Wes case referred to medical examiner? | n anitali | | | | Plece of De | eath (Check only | ona) | | | |
| 5 | this o | . To | 1 Yes 2 No | | | patient 3 DOA | | Nursing | Home 5 Res | | | | |
| VISION | ending Feeth. or: After the funer | Certification: | Natural 5 Pending investigation | 28a. Date of Injury (Month, Day Year) | 28b. Tir Inj | ne or 28c. | Injury at Work? 1 Yes | 2 🗆 No | 28d. Describe | now inj | ury occurr | rea | |
| 22 | Ital or Att its after d al Direct lled in by | | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Richard City or Town, Stete) | | | | | | | | | er or Rural F | Routa Number, |
| | To the Hospital or Attending Pr within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral | ledical | (Check only 2 Medical Examin | cian: To the best of my know er: On the basis of examinet end menner steted. | /ledge, on end/ | or investigation, in | my opinio | n, deeth occ | e, and due to the urred at the time | , date a | nd place, a | and due to th | ne cause(s) |
| | To T com | M | 29b. Signature end title of cartifier | | | | 464 | | | | _ | d (Month, De 6 , 19 | |
| 5 | 1 VA | | 30. Name and address of person who con | npleted cause of death (Item | 23a) (T | ype, Print) | | | | | | | |
| | | | Ashvinkumar Pat | el, M.D. 6 | Indu | strial D | rive | Wald | orf, MD | 206 | 01 | | |

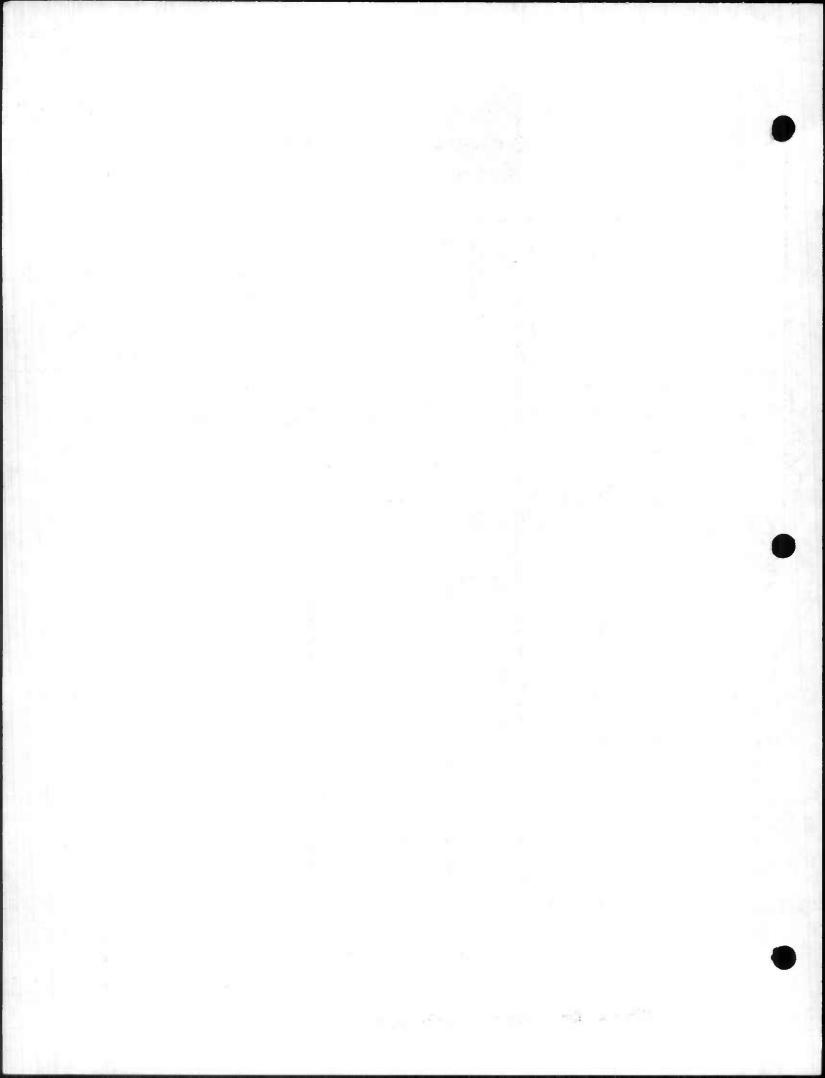
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Q

| | | | Certificate of Death | | Reg. No. | 9 | 3016 |
|----------------------------|--|---------------------|--|---|-------------------------|------------------------------|---|
| | Dhusisi | | Decedent's Neme (First, Middle, Last) | 2. Date of De | | Year | 3. Time of Death |
| | Physici /Medio | | WILLIAM M. REED | April | 814 | 1199 | 13:22 PM |
| | Examir | er | 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or | | | y of Death | |
| | | | Sunvise Rehabilitation Elky | | | cil | |
| | Funeral Director | Ĭ | 5. Sociel Security Number 222-05-4298 6. Sex 120 M 2 F 98 7. Age (In yrs. last birthday) Yrs. 1 Months 1 Under 1 Year 1 F Under 24 Hr. 1 Months 1 Deys 1 Hours 1 Min 1 Under 1 Year 1 F Under 24 Hr. 1 Months 1 Deys 1 Hours 1 Ho | . (Month, De | th by, Year) 1901 | | lace (State or Foreign htry) aware |
| | and w | | 10a. State 10b. County 10c. City, Town or Location | | | 1 | 0d. inside City Limits |
| | Mary | tor | Delaware New Castle Townsend | | | | 1X Yes 2 □ No |
| | r 28a | Irec | 10e. Street end Number 10f. Zip Code | | 10g. Citizen of | What Coun | itry? |
| | h with | al D | 796 Dexter Corner Rd. 19734 | | USA | | |
| 21215-0020 | permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiens. Department of Heath and Mental Hygiens. Important: If flem 27 is marked other than "naturel", or items 28s or 28s-f show any Injury or other treumstic event, the Maccal Examiner must be notified at any injury or other treumstic event, the Maccal Examiner must be notified at one. | by Funeral Director | 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Yes, Specify Cuban, Mexican, Puer or Dates: 13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Puer or Dates) 1 ☐ Yes 2 ☐ Yes (Sive Year or Dates) | Specify Yes or No to Rican, etc.) | | ce - Americ ack, White, o | etc. |
| | 72 ho | ted | 15. Decedent's Education 16e. Decedent's Usuei Occupation (Specify only highest grade completed) (Give kind of work done during most of wo | akina | 16b. Kind of E | susiness/Inc | dustry |
| 7 | Ithin range | Completed | (Specify only highest grede completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired) | nkuig | | | |
| 2 | ed w | Co | 12 Farmer | | Agric | | re |
| and a | be fill d oth | Be | *** 3 3 1 | me (First, Middle | , Maiden Sume | me) | |
| 2 | d Mer narke | 10 | | ohnson | | 0.000 | |
| Maryland | and 2 s eaith an n 27 le r | | Ida Mannering 796 Dexter Corner | Rd.,To | ownsen | d, DE. | .19734 |
| Baltimore | Pages 1 ent of H nt: If iter ry or oth | | 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) | Date | 20c. Location | | |
| 1 = | mit. Sartm Sorta | | 4 Donation 5 Other (Specify) Townsend Cemetery 22. Name and Address of Facility DANIELS & HUTCH | 4-13-99 | Town | send, | ,DE. |
| m | Per | | | | | | |
| | | | 212 N. Broad St 23a. Part1. Enter the disease, or complications may caused the death. Do not enter the mode of dying, such as cardle shock, or heart failure. List only one cause on truth line. | . Mlaal c or respiretory e | rrest, | , DE . 1 | Approximete |
| 4 | Physician | | shock, or heef failure. List only one cause on the line | | | i | Interval Between Onset end Deeth |
| 9 | /Medical | | Immediate Cause (Final disease or condition | | | 1 | meens |
| | Examiner | | resulting In death) Due to (or as a consequence of): | | | | 742 |
| | P # | edicai Examiner | Type 2 diabetes mel | litus | | 4 | 1Unns |
| | rificate be axecuted g physician and as the burial-transit | хагл | | | | | |
| 68760 | be ay | aiE | Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): | | | | |
| 87 | cate phys | dic | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | |
| | ding | ZWe | d | | | į | |
| Box | e death ce the attendii hed for use | clar | | | | i | |
| P.0. | y the d | ysi | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | the cause of death? |
| Q. | es that the death cer igned by the attendin be datached for use | by Physician/M | dementia of the Alzheimen's type | 10 | Yes 21 No | 3 Prot | bebly Unknown |
| Division of Vital Records. | Attending Physician: The law requires that the death cer or death. sctor. After this certificate has been signed by the attendin by the funeral director, page 2 should be datached for use | Completed | cerebro vascular accident | 24a. Wes | an autopsy ormed? | ava cor | ere autopsy findings allable prior to mpletion of cause death? |
| <u>a</u> | The ate h | Son | | 10 | Yes 2 No | 10 | Yes 2□ No |
| /# | ysicien: The law is certificate has director, page 2 | Be | examiner/ | ath (Check only | one) | | |
| of | physic this c | 2 | | Home 5 ☐ Resi | | | r) |
| u C | Ing P | Certification: | 27. Manner of Deeth 28a. Date of Injury 28b. Time of Injury at Work? 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury at Work? | 28d. Describe | how injury occu | rred | |
| 100 | death death stor: | Icat | 2 Accident investigation 3 Suicide 6 Could not be | 28f Location (| Street on d Nive | har or Rum | of Pouto Number |
| <u>≥</u> | or A after Direction by | ertit | determined determined determined determined determined determined determined determined determined determined determined | City or To | wn, State) | Der or Hura | il Route Number, |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral | edical Co | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ | e, and due to the urred at the time, | cause(s) end m | anner as si | lated. the cause(s) |
| | thin the whole | Med | one) and manner steted. 29b. Signeture end title of cegifier 29c. License number | | 29d. Date sign | | |
| | F 3 F 8 | | Mollensham MD. 03577 | 9 | | | 9 |
| | | - | On Nicolanda Anna Caranta and | | | | r |
| 11 | 7 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. Bruce Obenshain, 251 S. Bahemia | Aug 1 | 2:14 | / n | 1/2/9/ |
| | Sta | | 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature | inve, c | e 0/1/6 | 14,1 | 0,2101) |
| | Sta Registra | | 31. Date filed (Month, Dey, Yeer) APR 1 2 1999 32. Registrar's Signature 4. Society | | | | |



State of Maryland / Department of Health and Mental Hygiene

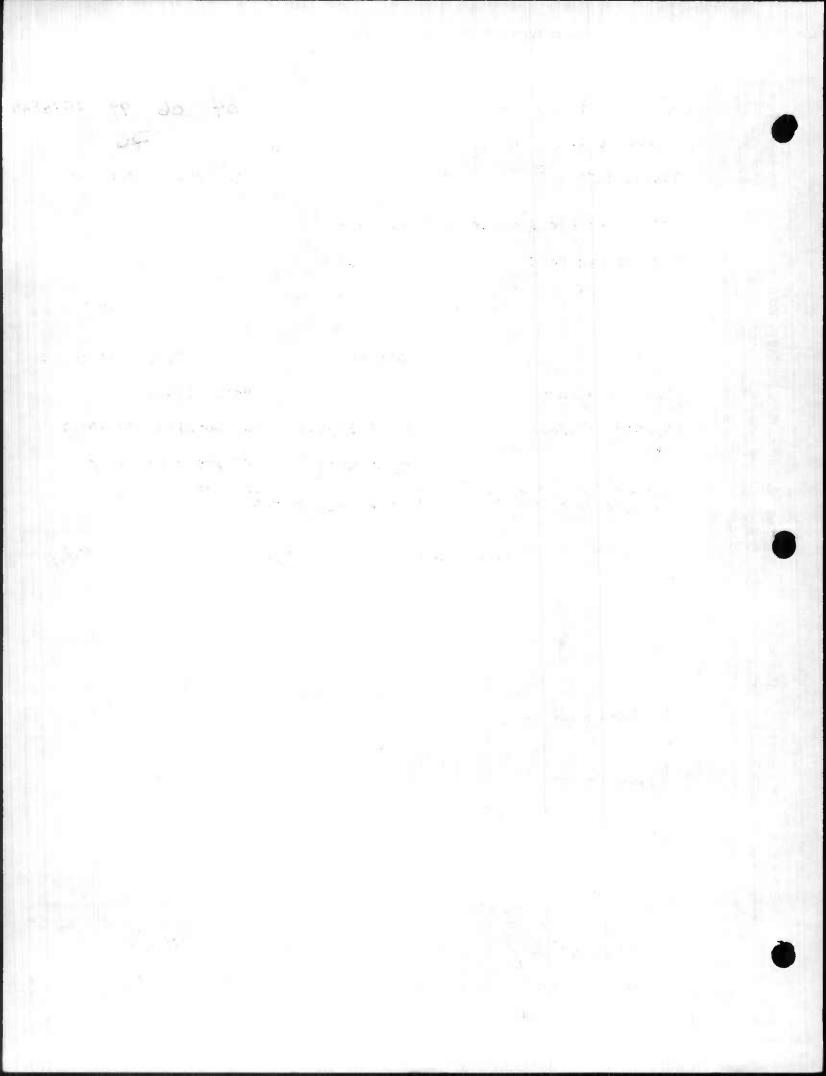
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Tima of Death Month 04 **Physician** Roby John 10:48 AM 06 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Laurel Regional Hospital
Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Laurel Hundar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2□ F Months Days Hours Yrs. Director 233-30-5850 Usual Residance of Dacedan 75 Maryland 3/13/24 the Maryland r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nes 2 No Director MD Prince Georges College Park 10e. Street and Number 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any highry or other traumatic avent, the Modical Examinational Data. Once. Funeral 5903 Berwyn Road 20740 USA 14. Hace - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forces? 1 (XYas 2 □ No If Yas, Giva Yaar or Dates: 1 0 5 5 Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Black, White, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: p 3 ☐ Widowad 4 ☐ Divorced 1955 white Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Engineer 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Be 10 Ruth Wilson Ona Dawes Roby 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cematary, crematory or other place)

Data

20c. Location - City or Town, Stata Raymond Roby/son 20a. Mathod of Disposition 1 M Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 4/9/99 Dunkirk, MD So. Mem Gardens 21. Signatura of Funeral Sarvica Licensaa 2. Nama and Addrass of Facility P.O. Box 121 23a. Part1. Ent the disease, or complications the cased the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause in such line. Approximate Interval Between Onset and Deeth **Physiclan** Immediata Causa (Final disease or condition rasulting in daath) /Medical acute myocrdist Examiner Examiner physician and the buriel-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medicai Dua to (or as a consequence of) 80 P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the causs of death? 1 Yas 2 No 3 Probably 4 Unknown Dissetes mellits Records, by 24b. Wara autopsy findings availebla prior to completion of cause of daath? 24a. Was an autopsy Completed Chronic obstructure poloney duck certificate has t hypertension
25. Wes case referred to medical axeminar? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital I or Attending Physician: director, Be 26. Placa of Death (Chack only one) Hospitel: Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yas 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funerai 26a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death.

Director: A in by the fu 2 Accidant 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, end due to the causa(s) and mennar es steted.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifian 29d. Date signed (Month, Day, Year) 29b. Signature and sitle of gertifier 29c. License number ano 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) versprog MD Michael A. Lincoln, M.O. 10313 Georgia Ave. 31. Data filad (Month, Day, Year) 32. Ragistra/s Signatura State 132 0 Registrar



WRC 99-1990-009 RALPH ODELL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 12211.

| RICE | | | | , | Ce | ertificat | e of | Death | | Re | ng. No. | 2 1 | 10014 | |
|--|------------------|--|--|--|-----------------------------------|---|------------------------|--|---------------------------|---|----------------------------------|--|--|--|
| Physici /Media | | 1. Decedent's Neme (First, Middle Ralph 0. | Rice | | | | | | 2. | Dete of Deat Month APRIL | Dev | Year 999 | Time of Death 8:28 AM. | |
| Examin | | 4a Facility Name (If not institution CALVERT MEMO | | | | | | 4b. City, Town | E FRE | DERICK | | alvert | | |
| Funeral Director | | 5. Social Security Number 214-30-0380 | 6. Sex 1 M 2 ☐ F | 7. Age (In yrs. 7 | | /) If Under Months | 1 Year Days | Hours 4 | Hrs. 8. | Dete of Birth (Month, Day 2 pt . 22 | 2, 1926 | 9. Birthplace Country) Mary1 | (Stete or Foreign and | |
| Varyland f ahow | or | Usual Residence of Decedent 10a. Stete 10b. County Maryland Cal | vert | 10c. C | ity, Town or I | Location | and | | | | | | Inside City Limits | |
| h with the 13a or 28a- | Funeral Director | 10e. Street and Number 5125 Hardesty | | | | 10f. Zip | | | | 10 | Og. Citizen of V | | | |
| d 21215-0020 Illed within 72 hours after death with the Maryland Hydiens. Hydiens, frether than "natural", or terms 23a or 28e-f show ent, the Medical Exercities must be notified at | by | 11. Marital Status 1 Never Married 2 Merri 3 Widowed 4 Divorced | Armed F | 2□No 19 | 1,5. 13 145- 146 | Was Deced If Yes, spec | | lispanic Origi an, Mexican, Specify: | n? (Specify Puerto Ric | y Yes or No- an, etc.) | Blac | e - American lok, White, atc. | ndien, | |
| Aaryland 21215-0020 2 should be filed within 72 hours aft and Mental Hyglens. I have returnal; or sumatic event, the veger Exert | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | grade completed | (1-4or 5+) | (Giv | edent's Usue te kind of wo DO NOT us carpent | rk done se retire | during most o | of working | | Cons | tructi | | |
| Baltimore, Maryland 212: semit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Hem 27 is marked other than any injury or other traumatic event, the Manage. | To Be C | 17. Father's Name (First, Middle, I Joseph J | ast) ohn | Ri | ce | -74 | | 18. Mother | | (First, Middle, Maiden Surname) Contee | | | | |
| e, Mar 1 and 2 ahd Health and Pm 27 ie m | | 19e. Informent's Neme/Reletions Eileen Rice/Wif | | | 5125 | Hard | esty | | Sund | lerland | 1, MD 2 | or Town, State, Zip Code) MD 20689 coation - City or Town, State | | |
| Baltimore, No permit. Peges 1 and Department of Health important: If them 27 any injury or other transcenter. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St | | n State | Place of Disposers, critical Hope | emetory or o | ther pie | | | | Sunder1 | | | |
| Baitim permit. Peg Department important: I any Injury o | | 21. Signeture of Funeral Service I | Seviels | 0 | | | | | | | eral Ho ce Fred | | MD 20678 | |
| Physician / /Medical Examiner | 9T | 23a. Pert1. Enter the disease, or shock, or haert leiture. List of Immediate Cause (Finel disease or condition resulting in death) | only ona cause on | erioscle | | Cardi | | | | | est, | Int | proximate erval Between eset and Deeth | |
| 58760, icata be executed physician and s the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disease or injury | b | Due to (| or es a conse | equence of): | | | | | | 1 | | |
| \$ D. | 95 | Cause (Disease or injury that initieted events resulting in death) Last | d | Due to (d | or es a conse | equence of): | | | | | | | | |
| - 0 0 % | Physician/ | Pert II. Other significant condition | ns contributing to | death but not res | sulting in the | underlying o | ause gir | ven in Pert I. | | 23b. Did to | bacco use co | ntribute to th | e cause of death? | |
| ords, P.O. | þ | | | | | | | | | | 98 2 No | | ly 4 (Unknown autopsy findings | |
| 2 × € € | Completed | | | | | - | _ | | | 24a. Wes e perform INSPE | ned? CTION | avalla | ble prior to etion of cause th? | |
| - F # A | Be Co | 25. Was casa referred to medical examiner? | | | | | | 26. Place o | of Death (C | 1 □ Ye | | 1 O Y | es 20 No | |
| G 6 7 == | 2 | 1XXYes 2□ No | | | ER/Outpati | ent 3 DC | DA Ott | er: 4 Nurs | sing Homa | 5 Raside | ence 6 Oth | ar (Specify) | | |
| E 5 5 | sation: | 27. Manner of Death 1XX Natural 5 Pending 2 Accident investig | ation | e of Injury onth, Day Year) | 28b. Time Injury | of M | 28c. Inju Wo 1 □ | ryat rk? Yes 2 □ N | | d. Describe ho | ow injury occur | red | | |
| Division Division The affector of the first of the firs | Certification: | 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide detarmi | ned 286. Plet | ce of Injury - At h ding, etc. (Speci | ome, ferm, s | treet, fector | y, office | | 281 | Location (St City or Town | reet and Numb n, Stete) | per or Rural R | oute Number, | |
| To the Hospital of within 24 hours at To the Funeral D completely filled | edical | 29a. Certifier (Check only one) | Physician: To the xaminer: On the and ma | e best of my kno basis of examino nner stated. | owledge, dea etion end/or i | th occurred investigation | at the ti | ma, date and opinion, death | place, and occurred | due to the ca at the tima, d | ause(s) and ma ata and place, | and due to the | d. e cause(s) | |
| within To the Comp | × | 29b. Signature and title of certifier | 11 | | | 290 | c. Licens | se number | | 2 | 9d. Deta signe | d (Month, De) | r, Year) | |

10+1

30. Name and address of person who completed cluss of death (Item 23a) (Type, Print) Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

32. Registrar's Signature

APRIL 06, 1999

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Monti Day **Physician** DORA ALVERTA SHERBERT April 11 1999 /Medical 12:15 pm 4a. Fscility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Undar 1 Year It Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yea. Birthplaca (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Yrs 94 **Director** 212 26 6707 Aug 11, 1904 Deale, MD Usual Rasidance of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Hashland Mental Hygiene. Important: If them 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Modes Examine must be notified as 1 ☐ Yes 2 X No Deale Directo Maryland Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20751 USA 5861 Rockhold Creek Road Funeral 12. Wes Decedent Ever in U,S. Armad Forces? Was Dacedant of Hispenic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Meritei Status 14. Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 💢 No If Yas, Giva Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ₩ Widowed 4 Divorced white Yaar or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales clerk retail dept. store 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumame) Be Marshall Rosa E Alfonzo Rogers 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mary L. Nutwell / daughter 5734 Nutwell-Sudley Rd., Deale, 20b. Place of Disposition (Nama of cematary, crematory or other plece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Deta 1

Burial 2 □ Cremetion 3 □ Ramoval from Stata 4-14-99 Deale, MD Sherbert Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Name end Address of Fecility loss Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Entar tha disaasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician Immediata Causa (Final disaasa or condition resulting in daath) /Medical Examiner Due to (or as a consequence of): Examiner physician and s tha burial-transit Sequantially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated events Dua to (or as a consequence ot): Box 68760. Physician/Medical that initiated events rasulting in daath) Last Dua to (or as s consequance of): attanding detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? tha signed by t 3 ☐ Probably 4 ☑ Unknown 1 Yee 2 No þ 24b. Ware autopsy findings sysilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peed has 1 ☐ Yas 2 Ø No 1 ☐ Yas 2 ☐ No cartificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific funaral director, Be 25. Was casa retarred to medical axaminer? 28. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidance 8 Othar (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatiant 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No in by tha 6 Could not be datermined 3 Sulcida 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred st tha tima, date and piece, end dua to tha causa(s) and mannar as ststed.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and mennar stated. 29e. Certifier Medical completary 29c. Licansa number 29b. Signature and the of certifier 29d. Dete signed (Month, Dey, Year) D-18809 MI 30. Nema end sodrass ot person who complated causa of death (Itam 23a) (Type, Print) Barbara Furlow, MD Annapolis, MD

Registrar

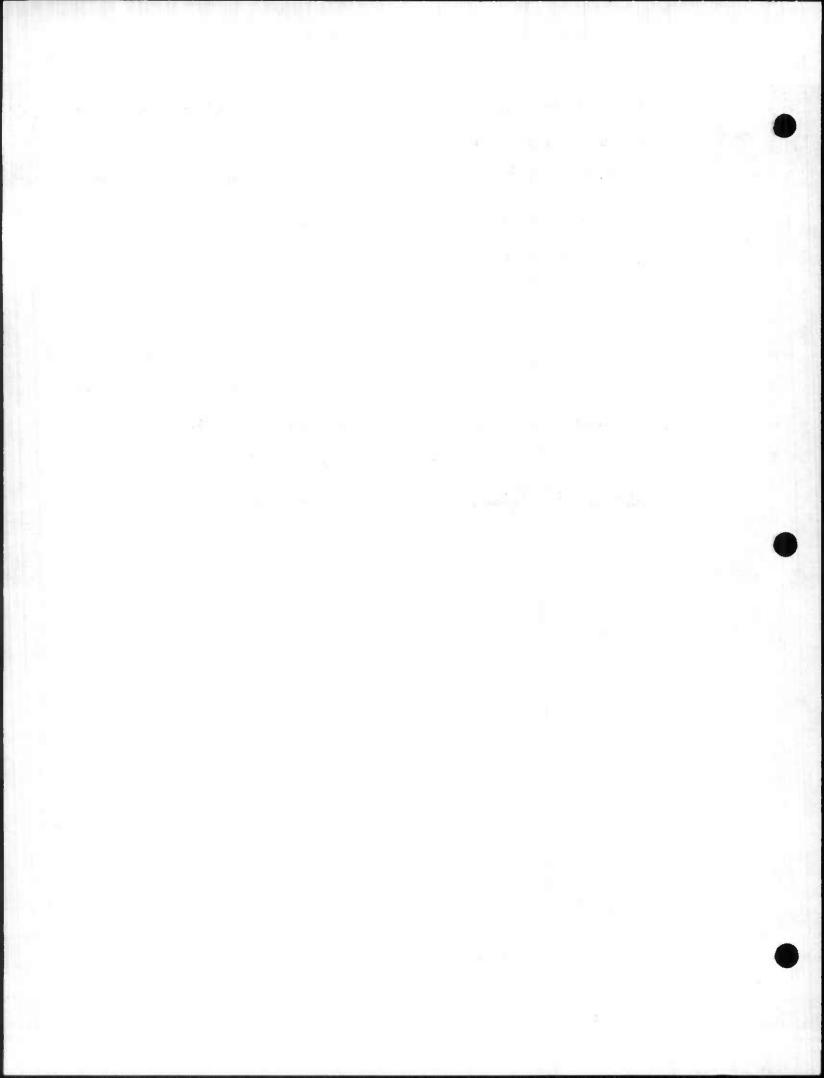
State

31. Data filed (Month, Day, Year)

APR 12

1999

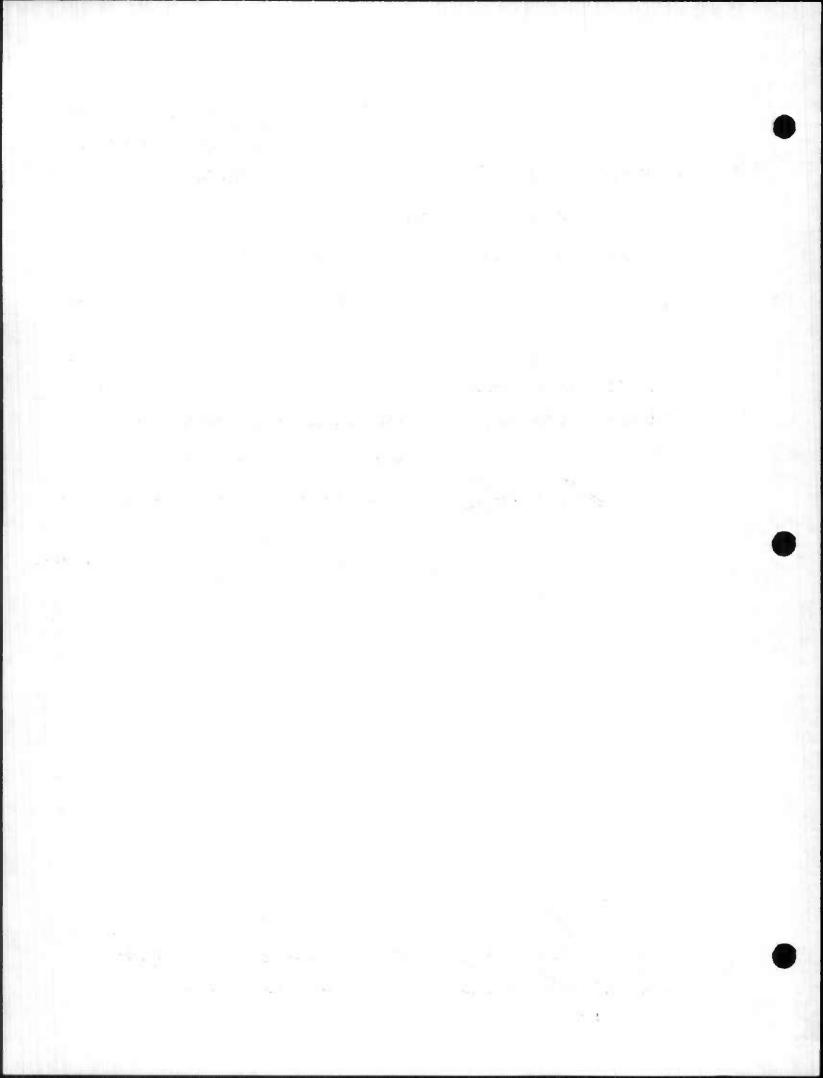
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

| 1 | 0 | (1) | 1 | 0 |
|---|---|-----|---|---|
| | 3 | 6 | 1 | 0 |

| | | | | | | Cei | rtificate o | f Death | | Re | g. No. | 2 | . 0 0 1 0 |
|------------|--|------------------|---|------------------------------------|---------------------------------------|-------------------------------|--------------------------------------|-------------------------------------|------------------------------------|-------------------------|--------------------------------|-------------|--|
| П | | | 1. Decedant's Nama (First, Middla, Li | est) | | | | | | of Deait | 1 | V | 3. Tima of Death |
| | Physic | | MICHAEL | | | SL | AVICH | | Apr | | 9 19 | Yaar 199 | 6:45 am |
| | /Medi Examii | | 4a. Facility Nama (If not institution, gi | va street and nu | mber) | | | 4b. City, Town | n, or Location o | | 4c. County | | |
| 7 | Exami | | 290 Southland (| Court | | | | Dunkir | k | | An | ne A | rundel |
| r | Funerai | Г | | Sax | 7. Aga (In yrs. la | st birthday) | If Undar 1 Yas | | 4 Hrs. 8. Date | a of Birth oth, Day, | | 9. Birth | placa (Stata or Foreign |
| 4 | Director | | 578 09 5218 | † ∑ M 2□ F | 86 | Yrs. | Months Day | S Hours | Min. Oct. | 5, | 1912 | PA | intry) |
| | p . | | Usual Rasidanca of Decedant | | 10. 00 | - | | | | | | | |
| | ehov det | 1 | 10a. Siata 10b. County MD Anne Aru | inde l | _ | Town or Lo | | | | | | | 10d. inside City Limits 1 ☐ Yas 2 ☐ No |
| | he M | ecto | | | Court | | | | | | | | |
| | E P P | 古 | 10e. Street and Number | na Desta | | | 10f. Zip Coda | | | 10 | g. Citizan of \ | What Cou | ntry? |
| | 23 | Funeral Director | 2307 Four Seaso | | | 140.1 | 210 | | 0.40 | | USA | | |
| | them ber de | In. | 11. Maritai Status | Armed Fo | | s. 13. y | Was Decedent of f Yas, specify Cu | Hispanic Origii Iban, Maxican, I | n? (Specify Yas Puarto Rican, a | s or No- iic.) | | ck, Whita, | ican indian, , atc. |
| 120 | s 1 and 2 should be filled within 72 hours after death with the Maryland f Health and Mental Hygiane. It has the state of the from 27 is marked other than "naturel", or items 29 or 28s-f show other treumstic event, the Medical Examiner mant be notified at | by F | 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yas if Yas, Gi Yaar or D | va | | 1□Yas 2 <mark>∏</mark> N | o Specify: | | | Specify | /: T | white |
| 21215-0020 | hou | P | 15. Decedent's E | | raras. | 16a Decer | sant's Usual Occ | upetion | | 1 | 6b. Kind of B | usinass/in | ndustry |
| 15 | in 72 | Completed | (Specify only highast gr | ada complated) | | (Giva | kind of work don DO NOT usa reti | a during most o | of working | , | ob. rand or bi | 20111000111 | loosily |
| 212 | iane. | E | Elementery/Secondary (0-12) | College (| 1-4or 5+) | _ | ant mana | | | | reta | il-b | akery |
| P | Hyge H | BeC | 17. Faihar's Nama (First, Middla, Las | () | | - | | - | s Nama (First, i | Middla, M | | | arter y |
| lar | lid be lenta ked ic ev | To B | Vasili Charl | es Sla | vich | | | Barba | ara | | | Zupel | k |
| Maryland | shou and N | - | 19a. Informani's Name/Ralationship | (Type, Print) | | | ng Addrass (Stre | | | | City or Town, | Stata, Zip | ip Code) |
| | | | Patricia L. Hic | ks (dau | g.) | 1512 | 0 Still | water P | lace, W | aldo | rf, MD | 2060 | 01 |
| re | S 1 8 He He He He | | 20a. Mathod of Disposition | | | aca of Dispo | sition (Nama of natory or othar p | iace) | Data | 2 | Oc. Location - | City or To | own, Stata |
| Baltimore, | pomit. Pages 1 and Department of Haalth Important: If Item 27 any Injury or other th 2009. | | 1 ☑ Buriai 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Speci | | Stata | - | oln Ceme | | 4-12- | 99 | Brentw | ood. | MD |
| alti | permit. Page Department of Important: If any Injury or once. | | | | | | | | | | | | |
| ä | Departiment in portion | | 11. 1162 | 1 m | 51 | R | ausch F | uneral 1 | Home. P |) A . | Owin | as. M | MD 20736 |
| | | | 23a. Part1. Entar iha disaase, or con shock, or haart failura. List only | npilcations that | ausad tha daath. | | | | - | - | | 30, 1 | Approximate |
| | Physician | - 5 | shock, or haart failura. List only | ona causa of a | ach lina. | | | | | | | | Intarval Between Onsat and Death |
| и | /Medical | | immediala Causa (Final diseasa or condition | | / | | | | | | | 1 | Gmos. |
| | Examiner | | resulting in death) | a | Dua to (g | as a consec | mance of): | | | | | - | GMOS, |
| _ | | ner | 1,00 | | 0 | 4 0011300 | durioo ory. | | | | | | |
| | death certificate be executed e attending physician and of for use as the burial-transit | Examiner | Sequentially list conditions | b | Dua to (or | as a conseq | uence of): | | | | | | |
| ó | an ar | EX | Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disaasa or injury that initiated avants | | | | | | | | | | |
| 68760, | yslci | Medical | thai initialed avants resulting in death) Last | c | Dua to (or a | as a conseq | uance of): | | | | | | |
| 39 | entifica ding pt | Ved | resulting in Geattly Last | | | | | | | | | İ | |
| Box | aath cer attendin I for use | | | d | | | | | | | | | |
| | a death the atte | Physician | Part II. Other significant conditions | contributing to de | eath but not rasul | ting in tha u | nderlying causa | givan in Part I. | 23 | b. Did tob | acco use co | ntributs t | to the cause of death? |
| P.0 | ta of | Phy | | | | | | | | 1840 | 8 2□ No | 3 Pro | bably 4 Unknow |
| S, | 8 5 8 | by | | | | | | | | | | | |
| Records, | v require been si should | ted | | | | | | | 248 | . Was an perform | | av | Vara autopsy findings vallable prior to |
| ec | 2 S | pldu | | | | | | | | | | | ompletion of causa f death? |
| | The law ata has t page 2 s | Completed | | | | | | | | 1 🗆 Yas | s 2 10 No | 1 | □Yas 2☐No |
| Vital | ysician: The sectificata director, pag | Be | 25. Was casa rafarred to medical axaminar? | | | | | 26. Piaca o | of Daath (Check | only one | 1) | | |
| of | D 10 7 | ၉ | 1 ☐ Yas 2 ☐ No | Hospital: | inpatiant 2 E | R/Ouipatien | i 3□ DOA C | her: 4 Nurs | ing Homa 5 | Rasider | nce 6 Oth | ar (Specia | ify) |
| | ng Ph ftar th ineral | ü | 27. Manner of Death 1 ■ Natural 5 □ Panding | 28a. Deta (Mon | of Injury th, Day Year) | 28b. Tima of injury | 28c. Inj | ury at ork? | 28d. Da | scribe hov | w injury occur | red | |
| Sio | Attending or death. octor: Aftai by the fune | cath | 2 Accidant Invastigation | | | | M 1 | ☐Yas 2☐No | 0 | | | | |
| Division | il or Attending Patter death. Director: Atter to din by the funera | Certification: | 3 ☐ Sulcida 6 ☐ Could not be datarmined | 28a. Place | of injury - At honing, etc. (Specify) | na, farm, str | eat, factory, offic | a. | | ation (Str. | | er or Run | ral Routa Number, |
| | ital o | | | | 7 | | | | | | | | |
| | Hospital 24 hours Funeral staly filled | edical | 29a. Cartifiar 1 Certifying Pt (Check only 2 Medical Exam | miner: On the bi | asis of axamination | ledge, deeth on and/or inv | occurred at tha restigation, in my | tima, data and propinion, daath | place, and dua occurred et the | to tha car | usa(s) and ma ta and placa, | innar as s | stated. to the causa(s) |
| | To the Hospital or / within 24 hours after Fo the Funeral Dire completely filled in b | Med | one) 29b. Signature and title of certifity | and man | ner stated. | | | nse number | | | | | |
| | P ₹ P 8 | | | | (| / | | | | | d. Data signe | , | Day, 1881) |
| | | | (| 7/ | | my | 1 | 3/60 | 2 | | 4/9 | 199 | |
| , | 0 | | 30. Nama and address of mirson who | , ,,, | e of death (Item : | 23a) (Type, | Print) | - 1 | 0 - | | - ' ' | | |
| - | | | 31. Data filed (Month, Day, Year) | | legistrar's Signatu | Iro. | Bours Bours | w, Me | W Zo | 7/4 | | | |
| | Sta Registr | | APR 1 | 2 1000 | Dener | | B. 1 | no de | , | | | | |
| | | "" | MILLY | ~ 1000 | | | - 19 | - Color | | | _ | | |



| | - | | | | | С | ertifica | te of | Death | | eg. No. | 7 1 | 3311 |
|---|---|--|---------------------|---|-----------------|--------------------------------|--|----------------------|---|---|----------------------------------|--------------------------------------|--|
| Physici /Medic | | 1. Decedent's Neme (First, Mi Mary | ddle, Last) | | | Tay1 | or | | | 2. Data of Dea Month April | | Year 999 | 9:50 A.M |
| Examir | | 4a. Facility Nama (If not institu 308 Thunderb | | | | | ib. City, Town, o Lust | Location of Deeth | 4c. County Ca | ot Death 1vert | | | |
| Funeral Director | | 5. Social Security Number 214-48-8024 | 6. Sex 1 ☐ M 26 | 7. Ag | e (In yrs. 6 | last birthdi 7 Yrs | Month | ar 1 Yaar Deys | If Undar 24 Hr Hours Mir | | 1931 | 9. Birthpl Count Mary | aca <i>(Steta or Foreigi</i> 17) Land |
| A 41 | | Usuel Residence of Decedent 10a. Stete 10b. Cou | | | 10c. Cit | y, Town or | Location | | | | | 10 | d. Inside City Limits |
| Meda | tor | Maryland Ca | lvert | | | | Lusby | | | | | | 1 ☐ Yea 2 🗓 No |
| e.not | Sirec | 10e. Street and Number | | | 1 | | | ip Code | | 1 | 0g. Citizan of \ | What Coun | try? |
| 1 23a | rai | 308 Thunder | | | | | | 2065 | | | | JSA | |
| "natural", or items 23a or 28a-f show edical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 🛣 N 3 □ Widowed 4 □ Divord | lerried 1 🗆 | a Decedant ned Forces? Yas 2X es, Give ar or Detes: | | .S. 1 | 3. Wes Dec If Yas, sp 1 \(\sum Yes\) | | ispanic Origin? (in, Maxican, Pue Spacify: | Specity Yes or No- rto Rican, atc.) | Bled | e - Amarica ck, White, e Black | etc. |
| netur | eted | 15. Deced (Specify only hig | lent's Education | leted) | | 16a. De | cedent's Us | uel Occup | ation during most of w | orking | 16b. Kind of B | usiness/Ind | ustry |
| than | Completed | Elementery/Secondery (0-1: | | lege (1-4or | 5+) | `life | | use retired sewif | | | Own I | lome | |
| I Hygiene. other than rent, the M | Be Co | 17. Fathar'a Name (First, Midd | lla, Last) | | | | 1100 | 001121 | | eme (First, Middle, i | | | |
| Mental arked o | To B | Rufus | | На | wkin | S | | | Mary | | 1 | Reed | |
| Health and em 27 is me ther traum | 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town 6217 7th Street NW Washington, D. C 20e. Method of Disposition 20b. Piece of Disposition (Name of Data 20c. Location | | | | | | | | | | | | |
| 5 2 0 | | 20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other | | I from Stete | | | sposition (A remetory of UM C | | ce) Cem. | Data 4/13/99 | 20c. Location - Dunki | | |
| Department Important: I any Injury o once. | | 21. Signature of Funerel Sarvi | ce Licensaa | ell | | 1 | | | | ewell Fun | | | , MD 2067 |
| A stranging physician and and are seen as the burial-transit | n/Medical Examiner | disease or condition resulting in death) Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last | b | | Due to (co | raaa con | sequence of a better | sch, | | And Frankliple | suling con | place | hons |
| 4 4 | Physician/M | Part II. Other significant cond | itions contributing | g to death b | ut not res | ulting in th | e underlying | cause giv | en in Pert I. | | | | the cause of death |
| been signed by should be detac | þ | | | | | | | | | 24e. Was a | | 24b. Wa | ebly 4 Unknown ire autopsy tindings illable prior to |
| has Je 2 | Completed | | | | | | | | | 1 D Y | ea 227No | of c | npletion of cause leath? |
| s cartificata director, pag | BeC | 25. Wes case referred to med examiner? | ical | | | | | | 26. Place of D | eeth (Check only or | - 1 | | |
| ter this meral di | 2 | 1 Yes 2 No 27. Menner of Deeth Neturel 5 Pen | | 1 ☐ Inpatie Dete of Inju (Month, Da | ry | ER/Outpa 28b. Time Injur | of | 28c. Injun Wor | 4 U Nursing | Home 5 Reside | ence 6 Oth | |) |
| within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 Sulcida 6 Cou | ld not be | Place of Inj building, et | ury - At ho | oma, farm, | street, tacto | ory, office | | 28t. Location (S City or Town | treet end Numb n, Steta) | per or Rura | Route Number, |
| 24 hour Funera etely fills | edical | 29a. Certifier (Check only ana) 2 Medic | al Examiner: On | To the best the basis of menner sto | examine | wledge, de tion and/or | ath occurre Investigetion | d at the tin | ne, dete end pled pinlon, daeth occ | ce, and due to the courred et the time, d | euse(s) and ma ete and plece, | anner as st and due to | ated. the cause(s) |
| To the | Me | 29b. Signeture and title of cert | - | |) | | 2 | 9c. Licens | a number | 2 | 9d. Data signe | d (Month, I | Day, Year) |
| | | • | M | 6 | | | | 2 | 33123 | | 4 | 1-90 | 1 |
| | | 30. Neme and eddress ot pers | + 1 | / | - | | | | , , , | | | | 1 |

and the second s

P P P

State of Maryland / Department of Health and Mental Hygiene

| | | | | Certifica | ate of | Death | | Reg. No. | - | 3310 | | | | |
|--|--|--|--------------------|--|--------------------------------|---|---|----------------------------|-----------------|---|--|--|--|--|
| Dhysisian | 1. Decedent's Name (First, Middle, Las | | | | | | 2. Date of Dea | Day | Yeer | 3. Time of Death | | | | |
| Physician /Medical | | gar Blake Vau | ght | | | | April | | 999 | 1702 | | | | |
| Examiner | 4e Facility Neme (If not institution, give | | | | | 4b. City, Town, or I | | 4c. County | | | | | | |
| | Union Hospit 5. Sociel Security Number 6. Se | tal of Cecil | | | der 1 Yeer | E1kt | | h . | Ceci | | | | | |
| Funeral Director | | M 20 F 77 | | rs. Month | | Hours Min. | 8. Date of Birt (Month, Day March 1 | 8,1922 | Cour | place (State or Foreigntry) irginia | | | | |
| Pand Wall | 10a. State 10b. County | 10c. | City, Town | or Location | | | | | 1 | IOd. Inside City Limit | | | | |
| Mery rest | Maryland Ceci | 1 | | | P | erryvill | e | | | 1 ☐ Yes 2 N | | | | |
| r 28a | 10e. Street end Number | | | 10f. 2 | Zip Code | - | | 10g. Citizen of V | What Coul | ntry? | | | | |
| th with | 1427 Principio Fur | nace Road | | | | 21903 | | U. | S.A. | | | | | |
| n 72 hours effer death with the Meryland *nature!; or items 23e or 28s-f show edite! Examinet must be notified s! leted by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? MYYes 2 □ No fi Yes, Give Year or Dates: 194 | | | cedent of Foecify Cub | lispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | 14. Rec Bled Specify | ck, White, | ean Indien, etc. hite | | | | |
| hour tures | 15. Decedent's Ed | | | Decedant's Us | sual Occur | nation | | 16b. Kind of Br | | | | | | |
| c · a - | (Specify only highest gra | de completed) | - 100. | (Give kind of work done during life. DO NOT use retired) | | | uring most of working | | | 1 Center | | | | |
| filed within Hygiene. ther than end, the Men | Elamantary/Secondary (0-12) Twelve Years | College (1-4or 5+) | | Mai | ntena | ance | | Perry P | Point, Maryland | | | | | |
| = 1 5 0 | 17. Fether's Name (First, Middle, Last) | | | | | 18. Mother's Nan | ne (First, Middle, | Maiden Sumen | ne) | | | | | |
| | Frank | M. Vaught | | | | | Josephin | ne Copel | and | | | | | |
| d 2 should the and Men 7 to marke treumatic | 19a. Informant's Name/Relationship (7 | | | The same of the sa | | end Number or Ru | | | | Code) | | | | |
| | Larry G. Vaught (| | | | | dlay, Se | | | | 98136 | | | | |
| Peges 1 en ment of Heel ant: If Item 2 ury or other | 20a. Method of Disposition 1 🔯 Burlal 2 🗆 Cremation 3 🗔 4 🗆 Donation 5 🗀 Othar (Specify | Removal from Stata | cometer cometer | Disposition (A y, cremetory o r Memor | lame of rother pla ial (| Gardens | Dete 4/9/99 | Bel Air | | | | | | |
| permit. Pege Department of Important: If I any Injury or once. | Bel Air Memorial Gardens 4/9/99 Bel Air, Maryland 21. Sign ture of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, interval Between the cause of the cause of the death. | | | | | | | | | | | | | |
| ing physician end ing physician end es the burial-transit | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last | b. ARterio | o (or as a c | consequence of conseq | of): | L INFA | 158488 | | | | | | | |
| at the death certi d by the ettending eteched for use e Physician/M | | | | | | | | | İ | | | | | |
| res that the deal signed by the ell be deteched for by Physic by Physic | Pert II. Other significant conditions co | ontributing to deeth but not | resulting In | the underlying | g cause gi | ven in Part I. | | | | o the cause of deat bably 4 🕅 Unkno | | | | |
| gned b be dete by P! | | | | | | | , , | Yas 2□ No | 3 LIC | bably 400 Unkno | | | | |
| been should | | | | | | | 24e. Was perfo | an autopsy med? | a\ cc | ere autopsy findings reilable prior to empletion of cause death? | | | | |
| ate hes page 2 | | | | | | | 10 | res 2 No | 1 | ☐ Yes 2☐ No | | | | |
| ician: The certificate rector, pag | 25. Was case referred to medical | | | | | 26. Place of Dec | ath (Check only o | | | | | | | |
| | exeminer? | Hospital: 1 Inpatient 2 | ER/Out | tpatient 3 | DOA Oti | oer. | iome 5 Resid | | er (Speci | fy) | | | | |
| Attending Physic death. ector: After this by the funeral d | 27. Mannar of Death 1 Natural 5 Panding 2 Accident investigation | 28e. Date of Injury (Month, Day Year | 28b. T | ime of njury M | 28c. Inju Wo 1 🗆 | ry at rk? Yes 2 □ No | 28d. Describe I | now Injury occur | red | | | | | |
| tat or Attending P is effer death. al Director: After t led in by the funers Certification: | 3 Sulcide 6 Could not be datermined | 28a. Placa of Injury - A building, etc. (Spe | t homa, fer | rm, street, fact | ory, office | | 28f. Location (3 City or Tox | | ber or Rur | el Route Number, | | | | |
| To the Hospital or Atlanding I within 24 hours elet death: within 24 hours elet death: completely filled in by the funes Medical Certification | | ysician: To the best of my liner: On the basis of exam and menner steted. | | | | | | | | | | | | |
| withir To the Comp | 29b. Signature and title of certifier | | | 1 | 29c. Licens | se number | | 29d. Dete signe | d (Month, | | | | | |
| | Sough | <i>S</i> Ø | | | Po | 551435 | 5 | APRIL | 5 | 1999 | | | | |
| 30 x1 VA | 30. Name and address of person who describes the state of | completed cause of deeth (I | tem 23a) (| | | Street, | | Marvla | nd 21 | 921 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 0 7 1999 | 32. Registrer's Si | gneture | 1 | 1/2/ | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 345 PR.1 1999 Rosalie West /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Elkton Union Hospital If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar Birthplace (State or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Days **Funeral** Months 1□ M 2□XF South Carolina March 27, 1922 Director 231-20-8667 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-4 show any injury or other traumatic event, the Medical Example Front page. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Cecil Maryland Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive 21921 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 No tf Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Etemantary/Secondary (0-12) College (1-4or 5+) In her own home Homemaker 0 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Susie Little Leroy Daniels 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Print) Laurelwood Continuing Care 100 Laurel Drive, Elkton, Maryland 21921 Center/ Care giver 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemalery, crematory or other place)
Providence 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 9, 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 1999 Elkton, Maryland 22. Name and Address of Facility 21. Signatura of Funeral Service Licensee Hicks Home for Funerals, P.A. 1 when 103 West Stockton Street, Elkton, Maryland 21921 henrol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Exacer bation disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Diacle meel Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): attending pl Hyperteusia signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Yo 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed Is certificate has be director, page 2 s 2 0 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: after death.

Director: After this certifica 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) P 1 Yes 2 No 1 Doalient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Dalatural 5 Pending Investigation 1 Yes 2 No 2 Accident n 24 hours after des he Funeral Director pletely filled in by th 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

31. Date filed (Month, Day, Year) APR 0 9 1999

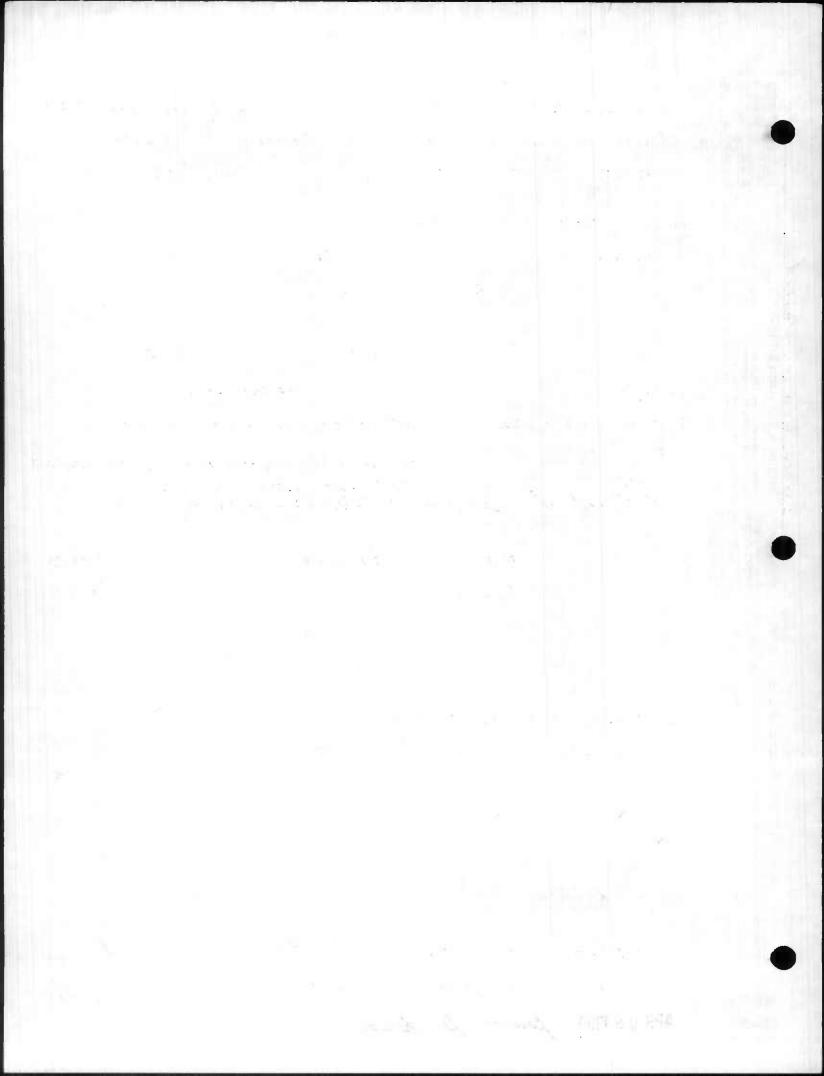
JUI CHIH HOU, MD 32. Registrar's Signature

Jui Chit Han MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

223 West main St. Ellow Md

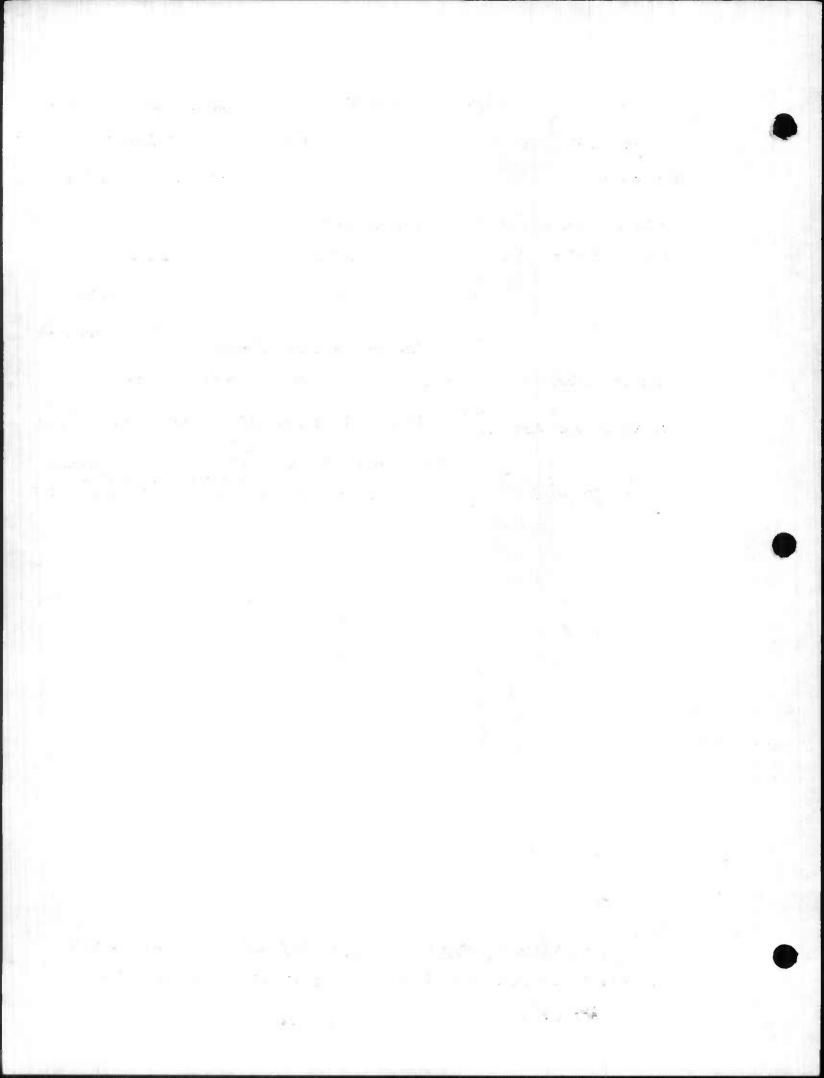
1 1.00

| | State of Maryland / Department of Health and Me Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 | Reg. No. | 3. Time of Death | | | |
|--|---|---|--|--|--|--|
| Physician | | Month Day | Year . TO A A | | | |
| /Medical | 45 City Town of Lock | tion of Death 4c. C | 1999 17. 207.19 County of Death | | | |
| Examiner | Union Hospital of Cecil County Eltton | | | | | |
| Funeral | | . Date of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) | | | |
| Funeral Director | 169-18-1612 1 M 2 X F 83 Yrs. Months Days Hours Min. J. Usual Residence of Decedent | une 2, 191 | 5 Virginia | | | |
| the Maryland r 28a-f ehow notified a | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits | | | |
| e Ma | Maryland Cecil Elkton | | 1. Yes 2 No | | | |
| or 2 | 10e. Street and Number 10f. Zip Code | | en of What Country? | | | |
| ath w | 1 Price Dr. 21921 | USA | | | | |
| vition 72 hours after death with the Maryland ena. than "naturel", or items 23s or 28s-1 show the Maryland and the market hard we must be notified a propleted by Funeral Director | | can, etc.) | 4. Race - American Indian, Black, White, etc. Specify: White | | | |
| 2 ho | 15. Decedent's Education 16a. Decedent's Usual Occupation | 16b. Kind | d of Business/Industry | | | |
| 1 21215-0020 ed within 72 hours af ed within 72 hours af ygiena. ner than "naturel", or ner than "naturel", or ner than "or properties of the Completed by F | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Low or with on the control of the control | | Hama | | | |
| DEPT O | | First, Middle, Meiden S | Home Surreme) | | | |
| E Selby W | | | | | | |
| Maryle d 2 should th and Mer T is marke traumatic | 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural F | Route Number, City or | Town, Stete, Zip Code) | | | |
| | Donna Benjamin/Daughter 1829 Tome Hwy. Port De | eposit, MD | 21904 | | | |
| 8 7 5 0 | 1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) | | ation - City or Town, State | | | |
| tim tmen tant: | 4 Donation 5 Other (Specify) Calvary Baptist Cemetery 4- | 10-99 Risi | ng Sun, Maryland | | | |
| Baltimo | 21. Signature of Funeral Service Licensee R. T. Foard Funeral H 1111 S. Queen St., Ri | Lina Sun A | | | | |
| Physician /Medical Examiner | 23a. Part Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cerdiac or reshoot, or heart feilure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in deeth) a. Multiplication for the mode of dying, such as cerdiac or resulting in deeth. Due to (or as a consequence of): | espiratory arrest, | Approximate Intervel Between Onset and Death 2 day 5 | | | |
| 68 / 60, ficate be executed physician end is the buriel-transit edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that imitiated events | | 3 day s | | | |
| BOX 68 / leeth certificate attending physi for use as the | | | 1 | | | |
| on deel the att the att when to ysick | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. | 23b. Did tobacco u | use contribute to the cause of death? | | | |
| that the detected detected | pulmonany hapentension | 1 ☐ Yes 2,5 | 3 Probably 4 Unknown | | | |
| of Vital Records, P.O. Box 68760, Physician: The law requires that the deeth certificate be executiviscent that been signed by the attending physician end ral director, page 2 should be detached for use as the bunel-transfer to Be Completed by Physician/Medical Exar | congestive heart failure | 24a. Was an autops performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? | | | |
| The large page | | 1 Ves 2 | No 1 Yes 21 No | | | |
| vital indicate certificate rector, pag | | Check only one) | | | | |
| Of Vita Physician: this certific ral director, | | 5 ☐ Residence 8 | Other (Specify) | | | |
| □ | | d. Describe how injury | | | | |
| DIVISION Control of Attending P within 24 hours after death. To the Funeral Director: After to the Funeral Director: After to the funeral Director and the funeral Director of After to the funeral Director of Completal filled in by the funeral Medical Certification: | 3 Sulcide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28i | f. Location (Street end City or Town, Stete) | f Number or Rural Route Number, | | | |
| To the Hospital or within 24 hours afte to the Funeral Dir completally filled in Medical Cert | 29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and considerable of examination and/or investigation, in my opinion, deeth occurred and manner stated. | | | | | |
| vithin To the | | 29d. Date | signed (Month, Day, Year) | | | |
| F 5 F 0 | Molersham MD 035779 | 41 | 17/99 | | | |
| 5 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | n - c | ~// a./ | | | |
| State | Wi Bruce Oben sharty M.D., 251 S. Bahamia 31. Date filed (Month, Dey, Year) 32. Registrar's Signature | Hue, Le | c.116n, Md | | | |
| Registrar | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

| | | | | State of Mary | | ertificate of | | | g. No. | 9 13 | 3321 | | |
|------------|---|---------------------|---|--|---------------------------------------|---|---|--|----------------------------------|---|--|--|--|
| | Physic /Medi | | 1. Decedent's Nema (First, Middla, La Pearl | Evelyn | Z. | issler | | 2. Deta of Death Month April 8 | Dav | 3.4 | Time of Death .0:00AM | | |
| | Exami | | 4a. Fecility Nema (If not institution, gh | re street and number) | | | 4b. City, Town, or Le | ocation of Deeth | 4c. County | of Deeth | | | |
| | | | Doctors Hosp | ital | | | Lanham | | Princ | ce Geor | ge's | | |
| | Funeral Director | | 386-10-9506-A | Sex 7. Aga (fn □ M 2 X F 80 | yrs. last birthdey Yrs. | Months Deys | | 8. Deta of Birth (Month, Day, May 5, | Year) 1918 | 9. Birthplace Country) Michi | (Steta or Foreign | | |
| | ryland | | Usual Rasidance of Decedant 10a. Stata 10b. County | 100 | c. City, Town or L | ocation | _ | | | | nside City Limits | | |
| | Se-f | cto | Maryland Prince G | eorge's | Uppe: | r Marlbor | .0 | | | 1 | Yes 2 No | | |
| | or 2 | Dire | 10e. Street and Number | - 1 | | 10f. Zip Coda | | 10 | | Vhat Country? | | | |
| | a 23a | eral | 9535 Nottingham | | h 110 10 | 2077 | | | U.S.A | | all a a | | |
| 21215-0020 | ges 1 and 2 should be filed within 72 hours after death with the Manyand to Health and Mental Hyglena. If flem 27 is marked other than "neturel", or theme 23a or 28a-f show or other traumatic avent, the Medical Examines must be mutified at | by Funeral Director | 11. Marital Status 1 □ Naver Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced | 12. Wes Decedent Ever Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: | in U,S. 13. | Was Dacedant of If Yes, specify Cub 1 ☐ Yas 2 ☒ No | Hispanic Origin? (Sp en, Maxican, Puerto Specify: | ecity Yas or No- Rican, atc.) | | e - Amarican Ir k, Whita, atc. ; Whit | | | |
| 5-0 | 72 h | Completed | 15. Dacedant'e E (Specify only highast gra | ducation ada completed) | 16a. Dece | dent's Usual Occu | pation during most of work ed) | ina 1 | | siness/industral Gove | | | |
| 121 | filed within Hyglena. ther than " | mpi | Elementery/Secondary (0-12) | Collega (1-4or 5+) | Lab. | Assitant | Harry Di | amond Lak | Legers | ir gove | riment | | |
| | filed within Hygiena. ther than than than | | 8th 17. Father's Neme (First, Middle, Last | N/A | | | | | | a) | | | |
| Maryland | 2 should be finand Mental It is marked of raumatic avairance | To Be | James Edwar | d Sulli | ivan | | Etta | a <i>(First, Middl</i> a, M Amanda | Wo | őds | | | |
| ary | should Men | F | 19a. Informant's Name/Ralationship (| Type, Print) (Son | 19b. Meil | ing Addrass (Stree | t and Number or Rur | al Routa Number, | City or Town, | Stata, Zip Cod | (e)20886 | | |
| | 1 and 2 Health a em 27 ia | | Sanford Clarence | | * 1 T QAA | 2 Mills | Choice Roa | ad #3 Mor | ntgomer | y Vill | age MD | | |
| ore | of He | | Sanford Clarence Zissler, II 19002 Mills Choice Road #3 Montgomery Vill 20a. Method of Disposition 1 M Burial 2 Cramation 3 Ramoval from Stata 20b. Pieca of Disposition (Nama of cematary, cramatory or other place) April Pala, 20c. Location - City or Town, cematary, cramatory or other place) | | | | | | | | | | |
| Ē | Pages ment of I ant: If its ury or o | | 4 □ Donation 5 □ Other (Special | Hamovai from Stata | | coln Cem | 1 | | Brentwo | od Mar | vland | | |
| Baltimore, | permit. Pages 1 and Department of Health important: If Item 27 any injury or other to once. | | 21. Signeture of Funaral Service Lice | al Hom | e, Inc. | | | | | | | | |
| | Physician /Medical Examiner | - A | 23a. Pant. Entar the disease, or comshock, or haert failure. List only Immediate Causa (Final disease or condition resulting in deeth) | a Colo | to (or as a conse | | e First and and and and and and and and and and | | | Inte | proximata rival Batween set and Death | | |
| Box 68760, | eath certificate be assecuted ettending physician and for usa as the burial-trensit | in/Medical Examiner | Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Causa (Disassa or Injury that initiated evants rasulting in death) Last | c. Pm | to for as a conse | , 50 | linne | fine | | | 2 Lugs | | |
| | death e ette ed for | sicia | Part II. Other significant conditions of | ontributing to death but no | t resulting In the | underlylna causa di | ven in Part I. | 23b. Did tob | acco use cor | tribute to the | cause of death? | | |
| s, P.O | requires that the death centeen signed by the ettendin hould be deteched for usa | by Physician/N | Ba | | | , , , , , , , , , , , , , , , , , , , | VOI 111 GIT 1. | 1 □ Ye | L | 3 Probably | | | |
| Records, | × 2 × | Completed | | | | | | 24a. Was an perform | | availab | utopsy findings le prior to ition of cause h? | | |
| | The ata | S | | | | | | 1 ☐ Yas | 2 0 No | 1 🗆 Ye | s 20 (No | | |
| /ita | cartificata rector, pag | Be | 25. Wes case referred to medical examiner? | 11.00 | | | | h (Check only ona |) | | | | |
| of Vital | 00 | 7 | 1 ☐ Yas 2 X No | | 2 ER/Outpatle | IN 3LI DUA | | ma 5 Rasidar | | | | | |
| Division | D 60 9 | Certification: | 27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation 3 Sulcida 6 Could not b | | | M 1 | Yas 2 No | 28d. Dascribe hov | | | | | |
| Divi | To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | 1 - | 4 Homicida datamined | building, atc. (Sp | pecify) | | | 28f. Location (Stre City or Town, | State) | | | | |
| | n 24 ho | Medical | 29e. Certifiar (Check only one) Certifying Ph 2 Medical Example | ysician: To the best of my niner: On the basis of exer and menner stated. | knowledge, deet minetion and/or in | h occurred at the ti ivestigation, in my | me, deta and piace, opinion, daath occurr | and due to the cer red at tha tima, dat | use(s) end ma le and place, a | nnar as steled and due to the | cause(s) | | |
| | Withi To th | M | 29b. Signetura end title of centifier | Mus No | n | 29c. Licen | sa number | , | _ | 8, 19 | | | |
| | 12 | | 30. Nama and address of person who Glenn R. Jaucia | completed cause of death | (item 23a) (Type O PA AVE | Print) enue #18 I | Upper Mari | | | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's S | Signatura | 6 | / | | | - | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death ANDREWS ANNA 04:30PM 1999 APRIL 20 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death CITY BALTIMORE THE JOHNS HOPKINS HOSPITAL If Undar 1 Yaar | If Undar 24 Hrs 7. Aga (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Yaar) 1□M 2□F Months Days Hours 164-20-2967 82 Yrs. MAR 11, 1917 Pennsylvania Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1X Yas 2 □ No McKeesport Allegheny 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1223 Pack St. 15132 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Nurses Aid Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) George Belohusen Unavailable 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) P. O. Box 19040, Alexandria, Va. Eugene Andrews 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data mcKeesport-Versailles Cem. 24/99 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) McKeesport, Pa. 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensas Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc lite U 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediata Causa (Finat disaasa or condition rasulting in daath) Aspiration Dua to (or as a consequence of) Dementia Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hip Abscess 24b. Wara autopsy findings availabla prior to complation of cause of daath? 24a. Was an autopsy performed? 1 ☐ Yas 2 K No 1 ☐ Yas 2 🕱 No 25. Was casa rafarrad to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding 1 TYas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one)

Examiner The law requires that the death certificate be executed ettending physician and for use as the bunal-transit Division of Vital Records, P.O. Box 68760, by the e signed by the should t 305 certificate or Attending Physician: this After within 24 hours after death.

To the Funeral Director: All completely filled in by the fu the Hospital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is merked other then "natural", or items 23s or 3 any injury or other traumetic event, the Weddes Erson as must be nonce.

Physician

/Medical

Examiner

Physician/Medical

A

Completed

Be

To

Certification:

edicai

page 2 s

funeral

Director

Funeral

þ

Completed

with the Maryland

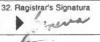
Registrar DHMH 16 Rev 6/95

W Bowerfind MD

29b. Signature and title of

31. Data fited (Month, Day, Year) APR 23 1999

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)



110

Johns

29c. Licansa number

RES-000

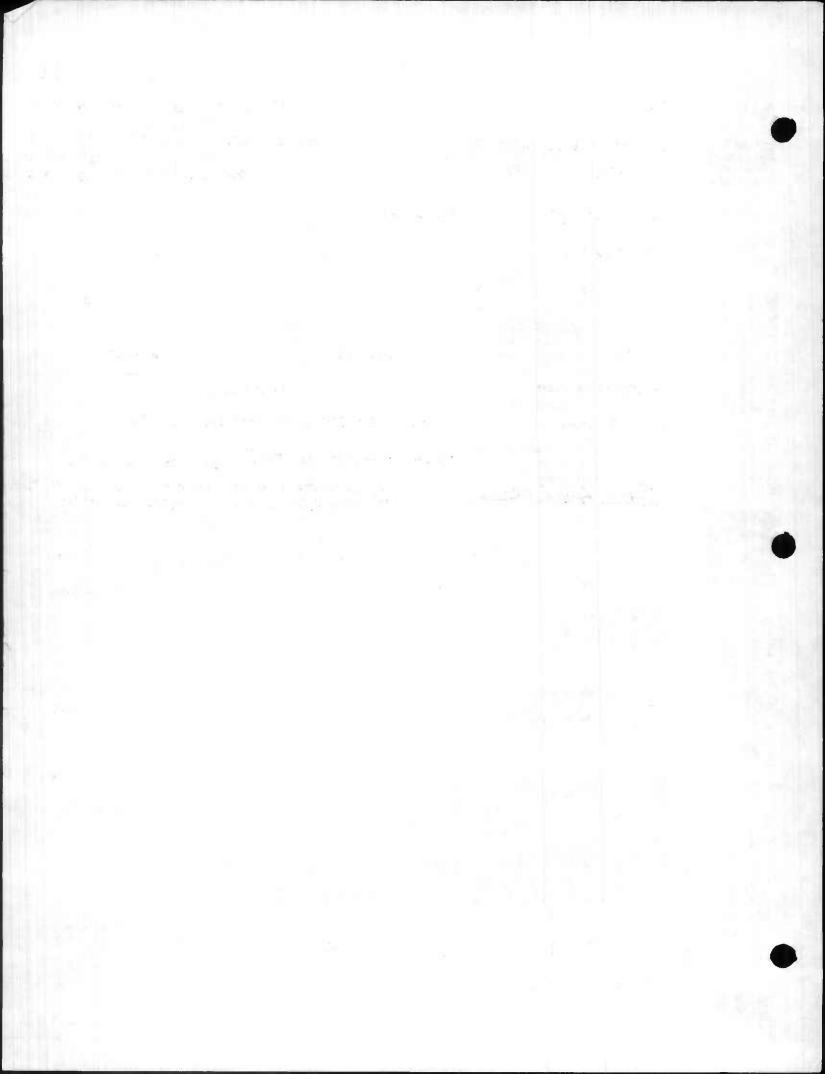
Hopkins Hospita

29d. Data signed (Month, Day, Year)

April 20

Tower

1: - A :



YEAR

3. TIME OF DEATH

DHMH-16 Rev 1/89

2. DATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

notified at o must examiner other traumatic event, the medical shows any Injury, item 23 6 is marked, 28 item THE HOSPITAL (THE FUNERAL D filed within 72 h Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

BALTIMORE, MARYLAND 21215-0020

hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. or removal filled in by cremation, completely and com attending physician a the atten signed by the peed has be certificate h this c. DIRECTOR: After the hours after death v

ELIZABETH RIDGELY APITZ 20 1999 10:30PM April 4. SOCIAL SECURITY NUMBER 5. SEX 6. AOE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 M 2 XF 98 218-50-8578 YRS July 1 West Virginia 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR AUGSBURG LUTHERAN HOME Lochearn Baltimore County 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Woodbrook 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 10 Meadow Road 21212 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 3 🔯 Widowed 4 🔲 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 8 th Homemaker Own Residence 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) <u>William</u> Ridgely Unknown by Informant BE 19a. INFORMANT'S NAME (Type/Print) 2 Ronald F. Heemann 916 Breezewick Circle, (P.R.) Towson, MD 21286 20s. METHOD OF DISPOSITION

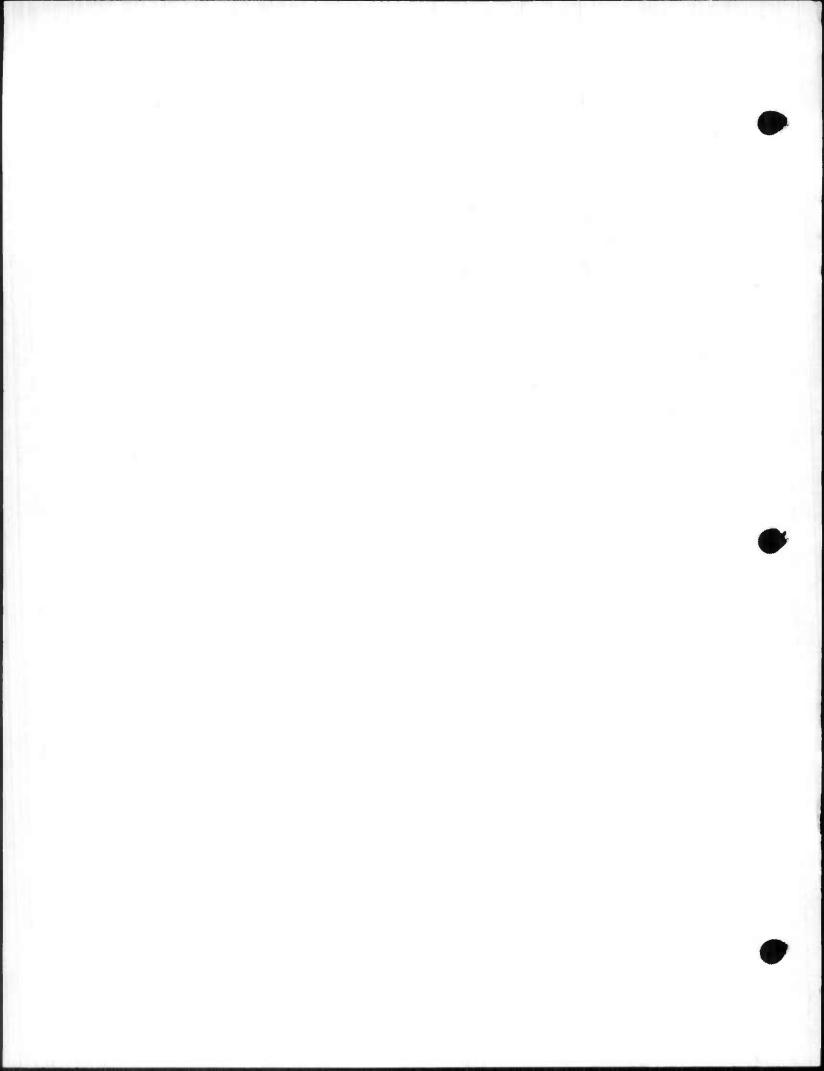
1 Suriel 2 Cremetton 3 Removal from State
4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Ivv Hill Cemetery Alexandria. Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Martin D. Bayson Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) a. ACUTE CORONARY THROMBOSIS

DUE TO (OR AS A CONSEQUENCE OF): 1 WESK CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10 1 | YES 2 | 140 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA rsing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be determined COMPLETED 4 Homicide 29e, CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 144593 / 29d. DATE SIGNED (Month, Day, Year) BE ►APRIL 21, 1999 wals 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PIENCE DEBORAH I 220 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE APR 2 1999



DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be



99-2285-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene HENRY WILLIAM Certificate of Death Reg. No. **ADAMS** 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician APRIL 20, 1999 11:51 AM Henry William Adams, II /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner APARTMENT 1002 BALTIMORE 110 WEST 39th 8. Date of Birth Month, Day, Year) MAR 1, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1₩ 2□ F 216-20-0267 72 Yrs. Maryland Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Berns 23a or 28a-f show 1 ☑ Yes 2 ☐ No Baltimore Director N/AMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 39th Apt. 1002 21210 110 West Funeral 14. Race - American Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried ☐Xes 2☐No Yes, Give natural, or Specify: White altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Writer/Author Writing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 should be financial to the marked of permit. Pages 1 and 2 should Department of Health and Man Important: If New 27 is marks To Henry William Adams. Jenny Knackman 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 E. 90th St. Cindy A. Adams/Daughter New York, NY 10128 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stele 1 Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/23/99 Baltimore, MD
22. Name and Address of Fecility 21. Signature of Funerel Service Licenses Cremation Society of Maryland, Inc. Edward A regorchik 299 Frederic

23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heer feilure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner certificate be executed and Sequentielly list conditions, if eny, leading to immadiete causa. Entar Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or as a consequance of): Box 68760 Physician/Medical the Due to (or as e consequence of) P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 2 NO certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Dey Year) Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending invastigation Attanding Neturel death. 1 ☐ Yes 2 ☐ No Accident hin 24 hours after death. the Funeral Diractor: A mpletely filled in by the fo 6 Could not be datamined 3 Suicide 28e. Placa of Injury - At homa, term, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner steted. To the I within 2 Tot 29b. Signetu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME APRIL 20, 1999 address of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 12. Régistrer's Signeture

Registrar **DHMH 16 Rev 6/95**

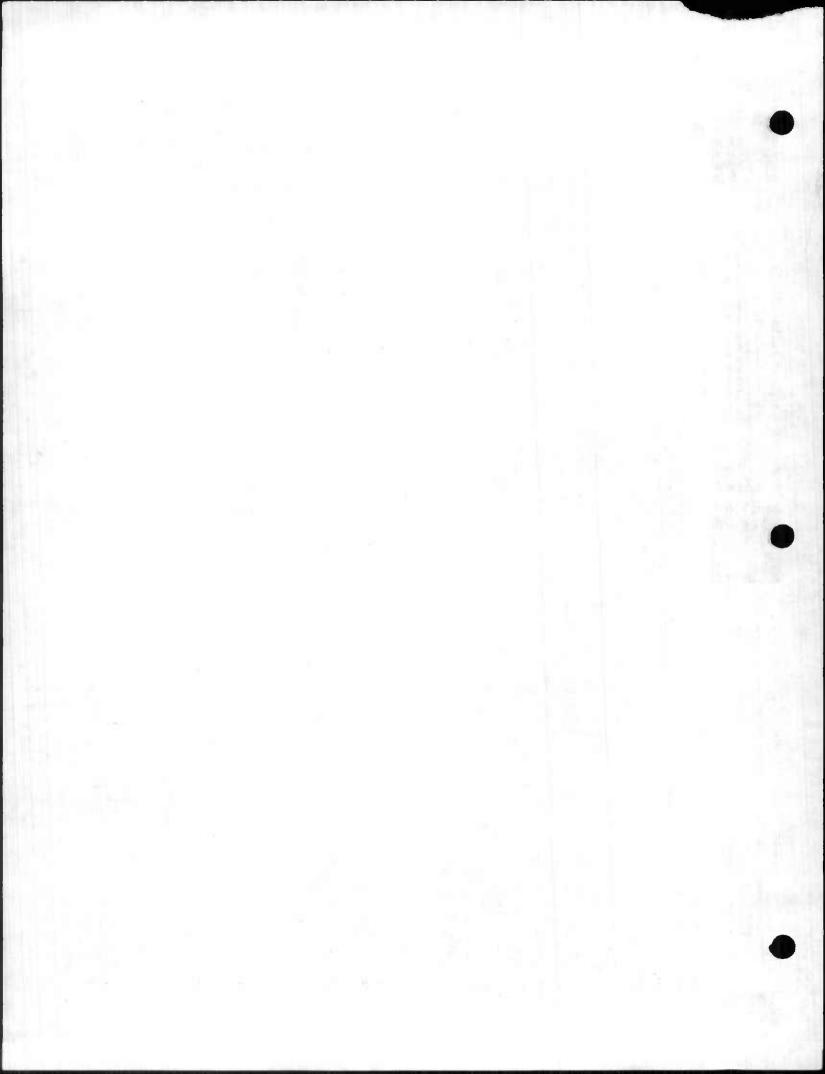
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31. Dete filed (Month, Dey, Year)

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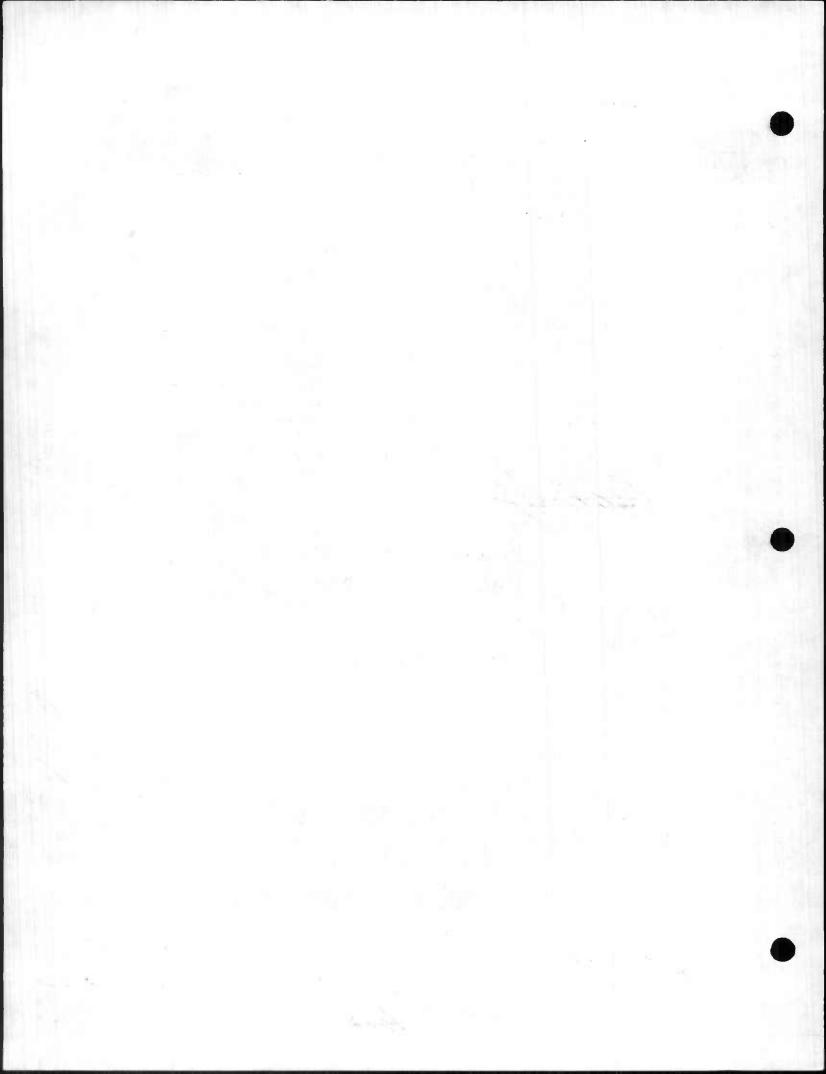
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State of Maryland / Department of Health and Mental Hygiene

| Self and Merital Hygiene. 27 le marted other tran "natural", or frama 23a or 28e-f ehow ar traumatic event, the Medical Examinet must be notified at To Be Completed by Funeral Director | 4e Facility Neme Eastpoi 5. Social Security 219-26- Usual Residence 10a. State MD 10e. Street and N 1046 No | of Decedent 10b. County Balti umber Orthpoint | e street and num eg Center Sex I M 2 RF | 7. Age (In yrs. 88 | s. last birthday, Yrs. Rity, Town or L Baltimo | Months Di | Baltin | | Balt | nty of Death imore | place (State or Fore | |
|--|--|--|---|---|---|---|---|---------------------------------------|---|------------------------------|--|--|
| the state of the s | Eastpoi 5. Social Security 219-26- Usual Residence 10a. State MD 10e. Street and N 1046 Nc 11. Marital Status | Number 6.9 -4087 of Decedent 10b. County Balti | ng Center Sex I□M 2対F .more Road | 7. Age (In yrs. 88 | Yrs. | Months Di | Baltin | more | Balt | imore | place (State or Fore | |
| stural, or items 23a or 23a-f show cal Estaminar must be notified at the contract of the by Funeral Director | 5. Social Security 219-26- Usual Residence 10a. State MD 10e. Street and N 1046 Nc 11. Marital Status 1 □ Never Me | Number -4087 of Decedent 10b. County Balti umber 0rthpoint | Sex 1□M 2QF 7 | 7. Age (In yrs 88 | Yrs. | Months Di | ear If Under 24 | | | 9. Birth | place (State or Fore | |
| stural, or items 23a or 23a-f show cal Estaminar must be notified at the contract of the by Funeral Director | 219-26- Usual Residence 10a. State MD 10e. Street and N 1046 Nc 11. Marital Status 1 □ Never Me | of Decedent 10b. County Balti umber Orthpoint | more Road | 88 | Yrs. | Months Di | | Min. 1/21/ | 1911 | 9. Birth Cou Ma: | ntry) | |
| 'natural', or frama 23a or 28a-f ehow solical Examinat must be notified at letted by Funeral Director | 10a. State MD 10e. Street and N 1046 Nc 11. Marital Status 1 □ Never Me | 10b. County Balti umber Orthpoint | Road | | | | | | | | ryland | |
| 'natural', or itema 23a or 28a-f eh solical Examinat mant be notified a letted by Funeral Director | 10e. Street and N 1046 No 11. Marital Status 1 Never Me | umber Orthpoint mied 2 Married | Road | 1 | Baltimo | | | | | | 10d. Inside City Lim | |
| 'natural', or frama 23a or 28 solical Examinal must be not letted by Funeral Direc | 1046 No | orthpoint | 12. Was Dece | | | ore | | | | | 1□ Yes 2√x | |
| "natural", or Itama 23a olical Examinat must b leted by Funeral [| 11. Marital Status | rried 2 Married | 12. Was Dece | | | 10f. Zip Co | de | | 10g. Citizen | ol What Cou | ntry? | |
| "natural", or Itama alco Esamene leted by Fune | 1 Never Me | rried 2 Married | 12. Was Deced | | | 212 | and the second second | | U.S. | | | |
| natur alical | | 4 LI Divorced | 1 Tes : | ces? 2 D No | U,S. 13. | Was Decedent If Yes, apecify 1 ☐ Yes 2 ☒ | | ? (Specify Yes or Puerto Rican, etc.) | fy Yes or No- can, etc.) 14. Race - American In Black, White, etc. Specify: White | | | |
| - E | (Sp) | 15. Decedent's Education (Specify only highest grade completed) | | | | | cupation | working | 16b. Kind o | Business/Ir | iduatry | |
| Department of reein and Mental hygiene, important: if item 27 ie marked other than "naturnanty injury or other traumatic event, the Madical pace. To Be Completed | Elementery/Secondary (0-12) College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry | | | | | | |
| | 17. Father's Name | Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) | | | | | | | | | | |
| c eve | Henry M | | | | | | Kather | ieilie/ | | | | |
| | * | | | | | | | or Rural Route Nuπ | | vn, State, Zij | p Code) | |
| 27 le | Charles | Keller | | | 507 | H. Cide | er Press | Dt. Jopp | a, Mary | land 2 | 21085 | |
| E 6 | 20e. Method of Di | • | ln 11 0 | 20b. | | osition (Name o | | Dete | 20c. Locatio | on - City or T | own, State | |
| 17.0 | 12 Obnation 5 Other (Specify) Holy Redeemer Cemetery 4/23/99 Baltimore, Marylan | | | | | | | | | | | |
| any inj | 1/4 | Service Lice the disease, or comert lailure. List only | ML | | 64 | 415 Bela | ddress of Facility | John C. Baltimor | e, Mary | | 21206 | |
| winding physician and use as the buriel-transit use as the buriel-transit un/Medical Examiner | Immediate Cause disease or condit resulting in death, Sequentially list of if any, leading to cause. Enter the Cause (Disease of thet initiated even resulting in death) | conditions, immediate Jerhyling or injury try | o. DE | ME Due to (| or as a conse | quence of): | ISEAS | E | | | | |
| for use a | | | | | | | | 1 | | 1 | | |
| be detached for use by Physician/M | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use 1 Yes 2 N | | | | | | | | | | / | |
| 2 should | | | | | | | | 24a. We per | es an autopay rformed? | a | Vera autopay finding vailable prior to ompletion of cause I death? | |
| Com | | | | | | | | 10 | Yes 2010 | 1 | □Yes ₽Z No | |
| B ector | 25. Was case refe examiner? | | Hospital: | | | | | Death (Check only | y one) | | | |
| F P | 1 Yes 2 No Hospitel: 1 Inpatient 2 EFVOutpetient 3 DoA Other: A Jurising H 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Deatural 5 Pending | | | | | | | | lome 5 ☐ Residence 6 ☐ Other (Specity) 28d. Describe how injury occurred | | | |
| pletaly filled in by the funer edical Certification: | 2 Maccident Could not be determined City or Town, State) Street and Number or Rural City or Town, State) City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) | | | | | | | | | al Route Number, | | |
| To the Funeral Di completaly filled in Medical Cer | 29a. Certifier (Check only one) | 1 Certifying Ph 2 Medical Exam | ysician: To the b niner: On the bas and manne | is of examina | owledge, deat ation and/or in | th occurred at the | e time, date end p ny opinion, deeth | place, end due to the | e ceuse(s) end e, dete end pled | menner as : ce, and due ! | stated. to the cause(s) | |
| Ne Me | 29b. Signeture and | d title of certifier | | | | 29c. Lie | cense number | | 29d. Date sig | ned (Month, | Day, Year) | |
| | Sa | inder | Woul | lle | MD. | . D | 27188 | | 41: | 22/ | 39 | |
| | 30 Name end add | of the state of th | completed cause | of death (Item L 2 gistrar's Sign | m 23a) (Type, _ Ma | elel- | lace | Balt | i here | MD. | 21222 | |

DHMH 16 Rev 6/95

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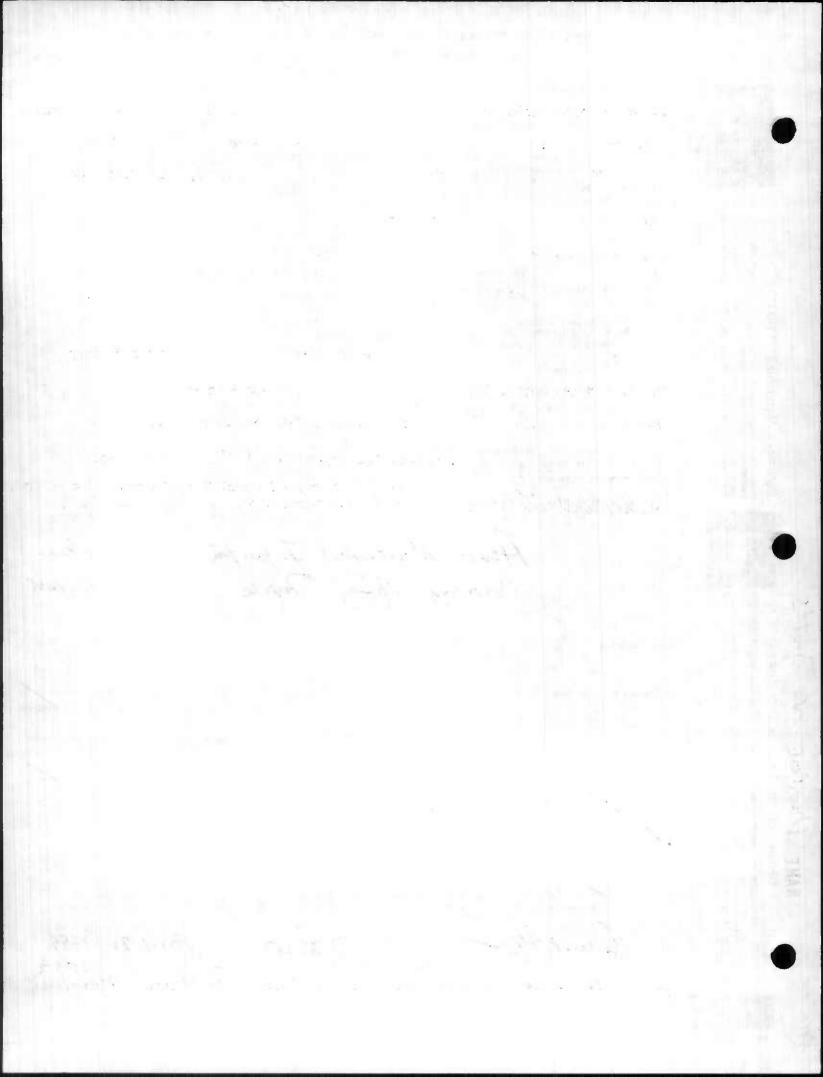


Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Dev Year **Physician** APRIL 20, 1999 Theodore Nolan Butts, Jr. 00:48 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** St. Agnes Hospital N/A Baltimore If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1QM 20 F Days Hours Min Yrs. JULY 5, 1935 217-30-3837 63 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at YOYes 2 No Baltimore Directo MD N/A 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 2530 Marbourne Rd. 21230 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes, 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Dover Poultry 11 ith and Mental Hygie 7 is merked other 1 traumetic event, tr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Ella Mae Murphy Theodore Nolan Butts, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Hem 27 Cenith Butts - wife 2530 Marbourne Rd., Baltimore, Md. other 1 altimore, 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Dete Pages Department of I 4/23/99 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Baltimore Washington Crm. Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) injury 22. Name end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signeture of Funeral Service License 7250 Washington Blvd., Elkric 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one caused the death. 7250 Washington Blvd., Elkridge, Md. Approximate interval Between Onset and Deeth **Physician** Myscarchel Immediate Cause (Final disease or condition resulting in death) /Medical Examiner 10 years Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Physician/Medical Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Vunknown by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed AME Theodore completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 217 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) Within 2 To the å 29d. Date signed (Month, Day, Year) April 20 1999 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scanlas new

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death April Day 1999 **Physician** 20, 1:00PM ROBERT **NELSON** BERWANGER /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 806 SEAWORD ROAD TOWSON BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day Year) June 6, 1949 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** XX M 2□ F Days Yrs 218-54-0091 49 Director Maryland Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be nothing at 1 Yes 2)(No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 806 Seaword Road 21286 USA Items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2XXNo þ 3 ☐ Widowed 4 ☐ Divorcad Specify: White "natural". Completed traumetic event, the Medical 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. int: If item 27 is marked other than " College (1-4or 5+) Elementery/Secondary (0-12) Bakery Manager Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Henry John Berwanger Margaretta Nelson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health or Important: If Itam 27 is any injury or other trau 806 Seaword Road Towson, Maryland 21286 Susan Hanley Berwanger Wife 20a. Method of Disposition
1 ☐ Burial 2AACremetion 3 ☐ Removal from State 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 4/22/99 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Greenmount Cemetery thurn of Funeral Section License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximete Interval Between Onset and Death Physician /Medicai Immediate Cause (Final disease or condition resulting in death) searca Examiner myanthema The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Que to (or as a consequence of):/ Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by tXX Yes 2 No 3 Probably 4 Unknown aucer þ 8 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? certificate has l 1 🗆 Yes XX No 1 ☐ Yes 20 No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28e. Date of injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? Medicai Certification: 5 Pending investigation 1XXNeturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homlcide within 24 hours eft To the Funeral Dir completely filled in Was Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.

2 Medical Examtner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L'adeullea mi D-24121 April 20, 1999 30. Name end address of person who completed cause of deeth (ttom 23a) (Type, Print)

Bruce Rosenberg M.D. 515 Fairmont Avenue Suite A Towson, Maryland 21286

32. Registrar's Signature

DHMH 16 Rev 6/95

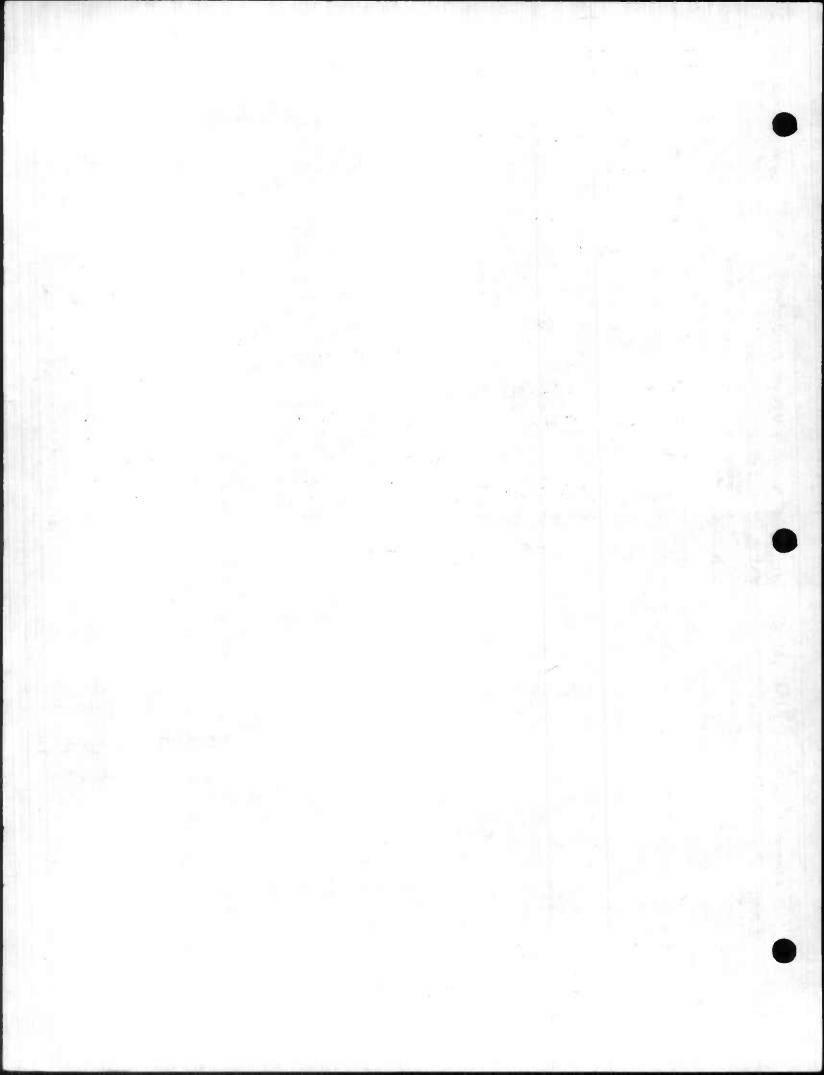
State Registrar 31. Date filed (Month, Dey, Year)

APR 2 8 1999

Parisa Hypla Heartha

| | ITEM: #29C PER MEO (| G770 4-23-99 WR. | C | Certificat | e of | | | lental Hy | Reg. No. | 77 | 133 | 328 | |
|--|--|--|------------------------------------|-----------------------------------|----------------|-------------------|------------|---------------------------------|----------------------|-----------|--|---|--|
| Physician | 1. Decedent's Nama (First, Mide | dle, Last) | | | | | | 2. Date of De Month | eath Day | , | Year 3. | Time of Death | |
| /Medical | DIANNE 4a Facility Name (If not instituti | | AKE | | | 4h Cily To | | APRIL Cocation of Deat | | County (| | 8:40 AM | |
| Examiner | 2922 GARRISON | MORE | | 46. | N/ | | | | | | | | |
| Funeral Director | 5. Social Security Number 238 19 8169 | 6. Sex 1□ M 2∏ F | 29 Yr | Months | 1 Year Days | If Under Hours | Min. | 8. Date of Bi | rth By (Sear) | | 9. Birthplace County) | (State or Foreign | |
| than "natural", or items 23s or 28s-f show he Medical Estatinat must be notified at ompleted by Funeral Director | Usual Rasidence of Decedent 10a. Stata 10b. Count | * | 10c. City, Town o | | | | | 100 | | | | nside City Limits | |
| be notified at Director | MD 10e. Street and Number | N/A | BAL | TIMORE 10f. Zip | Code | | | | 10a. Citi | izen of W | /hat Country? | ∏Yas 2□No | |
| a Di | 2922 GARRISO | N BLVD. | | | | 1216 | | | | USA | | | |
| by Funeral | 11. Marital Status 1 □ Nevar Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce | If Yes Giva | Ever in U,S. | 13. Was Deced If Yes, spec | X | | | ecify Yas or No Rican, etc.) | 0- | | - American Ir k, Whita, atc. : USA | odian, | |
| | 15. Decede | ont's Education est grade completed) | 16a. D | ecedent's Usua Give kind of wo | al Occup | pation | et of work | ina | 16b. Ki | ind of Bu | sinass/Industr | у | |
| Completed | Elementery/Secondary (0-12) | College (1-4or 5 | +) | ECURITY | se retire | FICER | 2 | | | CURIT | - | | |
| Be | 17. Father's Name (First, Middle FLOYD GOOD | | | | | | | E MAE I | | | θ) | | |
| 2 | 19a. Informant's Name/Ralation | nship (Type, Print) | | Mailing Addrass | | t and Numb | er or Run | al Route Numb | ber, City o | or Town, | State, Zip Cod | (e) | |
| | DEAN BUTLER/ H 20a. Mathod of Disposition | USBAND | 38 20b. Place of D | 14 PURI | | CIRCL | E RA | NDALLST Data | | | 21133 City or Town, | | |
| | 1 Burial 2 Cremation 4 Donation 5 Other (| | cemetery, METRO | crematory or o | ther pla | | 4 | /19/99 | | | , MD | State | |
| BOUG | 21. Signatura of Funaral Service | C Licergage | | 22. Nama an JAMES | d Addre | MORTO | N & | SONS F | .н., | INC | | | |
| | 23a. Part1/Enter the disease, | or complications that caused | the death. Do not | | | | | T BALT(| | 1D 21 | Apr | proximate | |
| lcian | shork, or heart tailure. Lis | st only one cause on each lin | ie. | | | | | | | | | rvai Between set and Death | |
| lical iner | Immediata Causa (Final disease or condition resulting in death) | a | ARDIAC ARR | HYTHMIA | | | | | | | 1 | - 11/11 | |
| xaminer | | | Due to (or es e co | nsequence of): | | | | | | | I | | |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b | Due to (or as a cor | nsequence of): | | | | | | | 1 | 4 5 | |
| by Physician/Medical | Cause (Disease or injury that initiated events rasulting in death) Last | C | Due to (or as a cor | sequence of): | | | | | - | | | | |
| and | | d | | <u> </u> | | | | | | | | | |
| ysic | Part II. Other aignificant condit | ions contributing to death bu | at not resulting in the | ne underlying c | ausa gi | ven in Part | I. | | | | | cause of death? | |
| by Pt | A F MI | | | | | | | 1 | Yea 2 | □ No | 3 Probably | y 4 ⊠ Un known | |
| Completed I | | | | | | | | 24a. Wes | s an autor ormed? | psy | availab | utopsy findings le prior to tion of cause h? | |
| Con | | | | | | | | VS. | Yes 2 | □No | †)⊠(Ya | s 2□ No | |
| To Be | 25. Was casa referred to medic examiner? 1 Yes 2 No | Hospitel: | nt 2 ER/Outp | atient 3 DC | Ott | hor | e of Deat | h (Check only | | 6 ∏Oths | ar (Specify) | | |
| ation: T | 27. Manner of Death 1 ⊠ Natural 5 □ Pend | 28a. Dete of Injur | | ne of 2 | 8c. Inju | | | 28d. Describe | | | | | |
| compietely filled in by the | 3 Suicide 6 Could deten | d not be mined 28e. Place of triju building, etc | iry - At home, ferm : (Specify) | , street, fectory | , office | | | 28f. Location City or To | (Street an | nd Numbe | er or Rural Ro | ute Number, | |
| compietely filled in by the funeral director, page Medical Certification: To Be Com | | ing Physician: To the best of Examiner: On the basis of and manner sta | examination and/o | | | | | | | | | | |
| Comp | 29b. Signature and titla of certifi | or I Charle | | 290 | . Licens | se number IE | | | | te signed | (Month, Day, | Year) | |
| | 30. Nama and addrass of person | n who completed cause of de | | rpe, Print) Penn | Stro | ot E | lal+i | more N | Marv1 | land | 21201 | | |
| | 24 Date filed (March Day Ver | | r'a Signature | LCIII | JULC | L | | oro, I | | | | | |
| State | 31. Data filed (Month, Day, Year APR 2 3 | | va / | | met. | | | | | | | | |

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death Month 1:00 a.m. Donner 4 nomian 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1102 Pleasantvalley Drive Catonsville Baltimore 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days 10 M 25 X Hours 212-22-0167 84 Yrs. April 13, 1915 NC Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 Yes 2XXIIIo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1102 Pleasantvalley Drive 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US. Federal Govt. mentary/Secondary (0-12) College (1-4or 5+) 9th Grade Mail Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Cornelius Bryant Emma Jane Mayo 19a. Informant'a Name/Reletionship (Type, Print) niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Phelps Lane Baltimore, Md. 21229 Merrion Raines 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation SOOther (Specify) Entombment Arbutus Memorial Park April 22 Baltimore, Md. 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses ethur 2501 Gwynns Falls PKWY Baltimore, Md. 21216 8. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Hemonnhobbe will Ston Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 18w/m Buserse

Physician /Medical Examiner

permit. Peges 1 and 2 should be filed within 72. Deperment of Health and Mental hygiena. Important; if item 27 is marked other than "natu any injury or other traumatic event, the Medical ones.

Physician

/Medical

Md.

Director

Funeral

g

Completed

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

deeth

72 hours effer

Baitimore. Marviand 21215-0020

Box 68760,

P.O.

Records.

Division of Vitai

physician end s the buriel-transit Physician/Medical attending p signed by the a p

Deen : hes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director;

Examiner Completed Be P

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 27. Manner of Death Certification: 29a. Certifier (Check only one) Medical

Registrar

Netural Accident 4 Homicide

1 Yes 28 No

5 Pending investigation 6 Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

CereBun

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Homa Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) TS confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

29c. License number

29d. Date signed (Month, Day, Year)

23b. Did tobacco usa contributa to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to

1 Yes

completion of cause of death?

1 Yan 21500

24a. Wes an autopsy performed?

1 Yes

28d. Describe how injury occurred

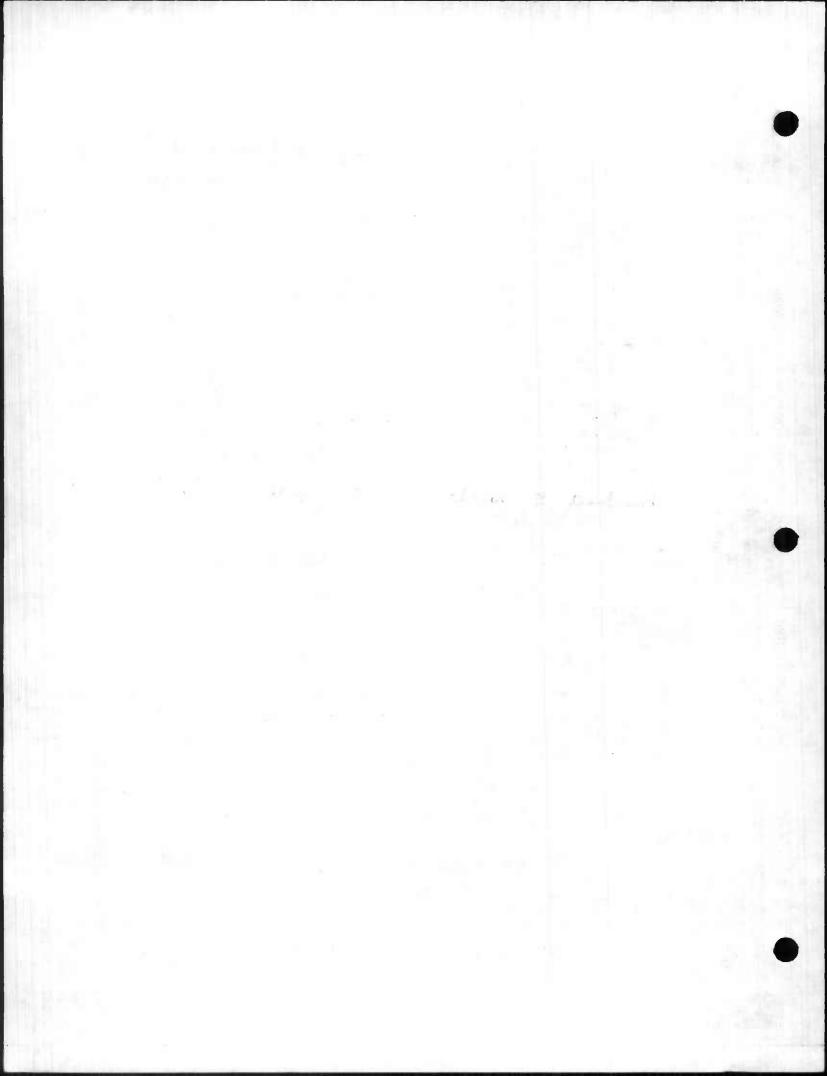
26. Place of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RRABA MAS RICE

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

@2. Registrar's Sign



Physician

/Medical

Examiner

Director

þ

Funeral

Director

"natural", or

Pages 1 and 2 should be filed within 72 ho nent of Health and Mentel Hygiene. unt: If Item 27 ie marked other then "natui .rry or other treumatic event, the Medical

Department of Important: If Its any Injury or o

Physician

/Medical

Examiner this

death.

Physician/Medical Examiner þ Completed Be To

Box 68760. P.O. Records, Division of Vital or Attending Physician: edicai Certification: To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A completely filled in by the fu

> State Registrar

29b. Signature and title of certifier

6 Could not be

3 ☐ Suicide

4 ☐ Homicide

uno.

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

29c. License number

1 Tes 2 No

Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Itedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

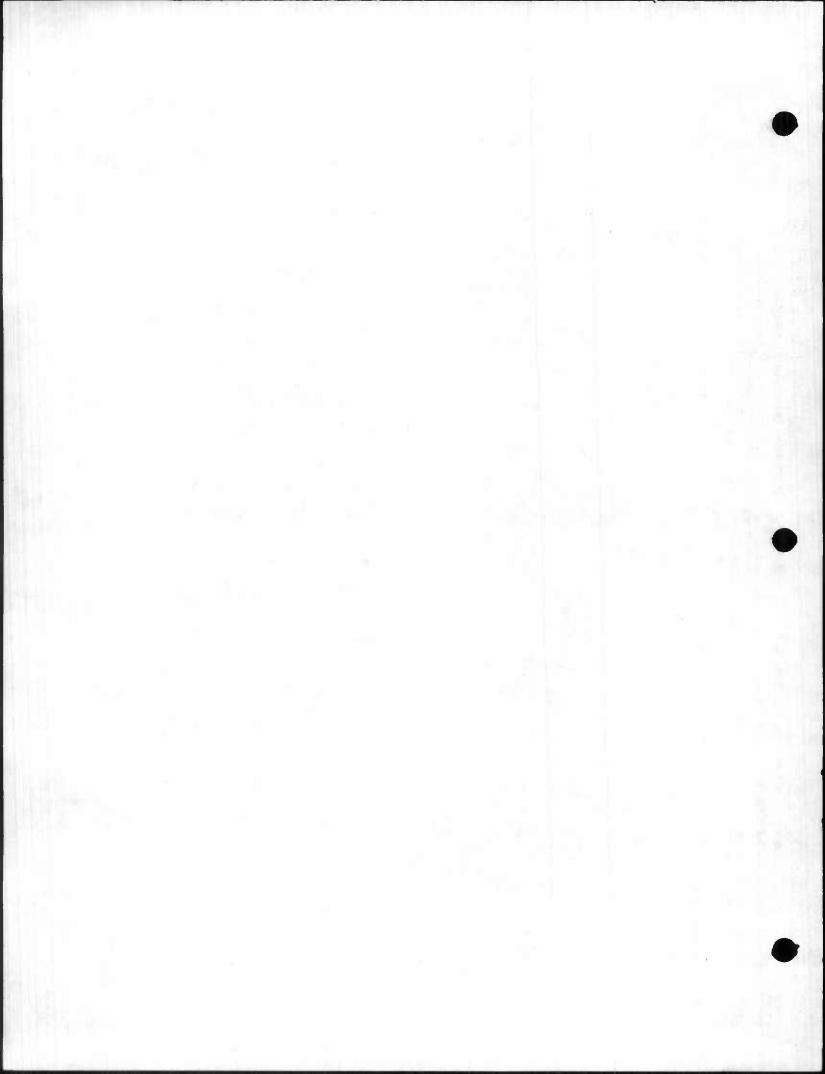
281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goubaly. ans 31. Data filed (Month, Day, Year) APR 2 3 1999

32. Registrar's Signature

Aquahact Rd. Glea Burne (40200)



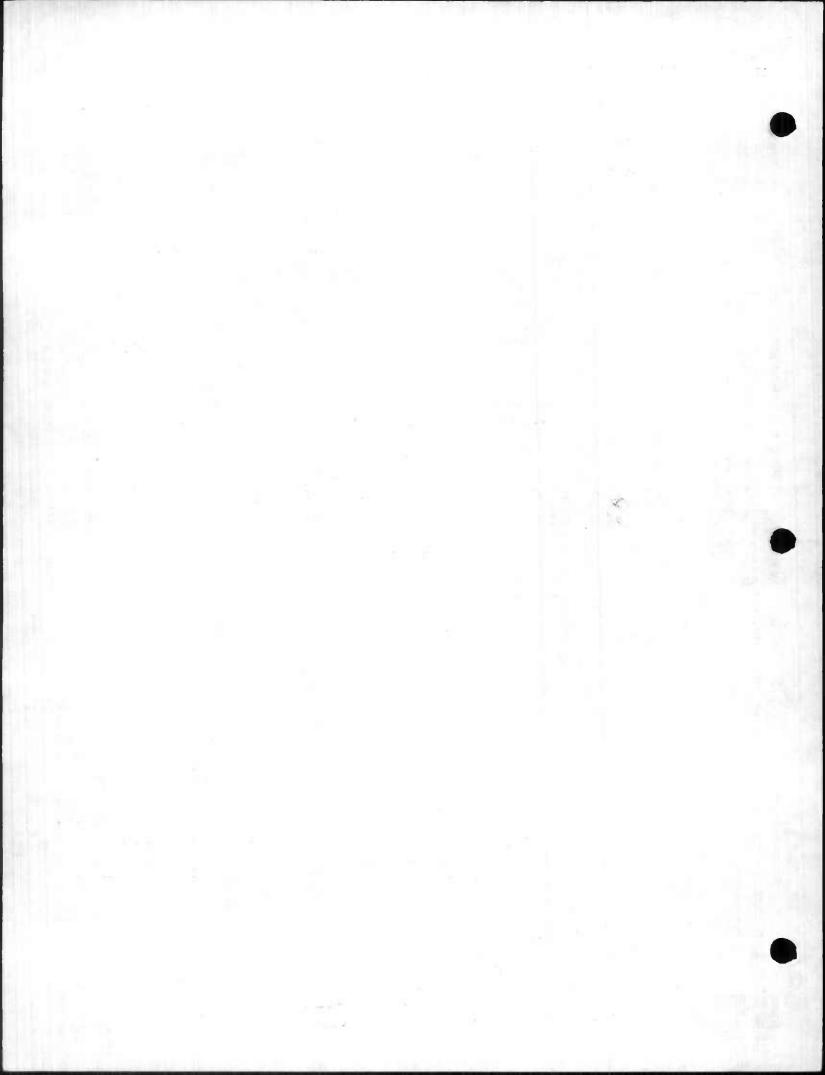
cm Anthony Bailey

State of Maryland / Department of Health and Mental Hygiene

| е | 9 | 0 | 1 | 0 | 0 | 9 | |
|----|---|---|---|---|---|---|--|
| 0. | J | 2 | | J | J | 3 | |

| : #23 [| ART I, 27, 28A-F PER 1. Decedent's Name (First, Middle, | | 6-99 WR. | Certi | iicale 0 | Dealli | 2. Data of De | Reg. No. | | 3. Time of | Death |
|------------------|---|---|------------------------------|--|---|-------------------------------------|--|---------------------------------|---|---|------------|
| ysiclan | ANTHONY M | | | | | | Month April | 16, 199 | Year | 1:52 | |
| Medical | 4a Facility Name (If not institution, | | | | | 4b. City, Town, or I | do. | | | 1.02 | T . T . |
| aminer | Sinai Hospital | | , | | | Baltimor | | N/ | | | |
| eral ector | 5. Social Security Number 217-84-7033 Usual Residence of Decedent | Sex 7. A | Age (In yrs. las 2 | | f Under 1 Yes fonths Day | | 8. Date of Bir (Month, Da SEPT 2 | iy, Year) | 9. Birthp Coun VIRG | lece (State o try) INIA | or Foreign |
| 1 10 | 10a. State 10b. County | | 10c. City, | Town or Local | ion | - HO | | | 1 | 0d. Inside Ci | ity Limits |
| nottiled at | MARYLAND N/A | | | BAL | TIMORE | CITY | | | | 1XXYas | 2 No |
| 百 | 10e. Street and Number 4113 CHATHAM RO | 207 | | 10g. Citizen of U.S.A | | itry? | | | | | |
| by Funeral | 11. Marital Status 1 XX lever Married 2 Marrie 3 Widowed 4 Divorced | Armed Forces 1 Yes 2X If Yes, Give | 1 ☐ Yes 2 X No | | | Cuban, Mexican, Puerto Ricán, etc.) | | | 14. Race - American Indian, Black, Whita, atc. Specify: BLACK | | |
| Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th grade | Education grade completed) College (1-4or | | Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) LABORER | | | rorking | | Business/Industry | | |
| S | 17. Father's Name (First, Middle, La | st) | | DADORI | - IX | 18. Mother's Nan | ne (First, Middle | , Middle, Maiden Surnama) | | | |
| o Be | RANDOLPH BAILEY | | DIANNE BRYANT | | | | | | | | |
| - | 19a. informant's Name/Relationship | (Type, Print) | | 19b. Mailing | Address (Stre | et and Number or Ru | ral Route Numb | er, City or Town, | State, Zip | Code) | |
| | Diane B. Bailey | /Mother | | 4113 (| Chathar | n Rd, Balt | imore, | Maryland | d 212 | 07 | |
| | 20a. Method of Disposition | Demovel from State | - | ce of Dispositi netery, cremat | on (Name of ony or other p | lace) | Date | 20c. Location | - City or To | wn, State | |
| | 4 Donation 5 Other (Spe | | KIN | NG MEMO | RIAL P | ARK | 4-24-99 | BALTIMO | RE, N | MARYLA | .ND |
| eny injury | 21. Signature of Funeral Service Lie | Drown | | W. | ILLIAM | ress of Facility C BROWN C | | Y FUNER | AL HO | ME PA | |
| il verification | Immediate Cause (Final disease or condition resulting in death) | a | | INJURIES | | | | | | | |
| Medical Examiner | Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| sician | Part II. Other significant conditions | | but not resulti | ing in the unde | riying cause | given in Part I. | 23b. Did | tobacco une co | ontribute to | the cause | of death? |
| by Physician/M | | | | | | | 10 | Yes 2□ No | | | Unknow |
| Completed | | | | | | | 24a. Was perfo | an autopsy ormed? | ava | ere autopsy i ailable prior i mpietion of o death? | to |
| | | | | | | | 1 | Yes 2□No | 1) | Yes 2 | No |
| Be | 25. Was case referred to medicat examiner? | Hospital: | -17 | 1 | _ | 26. Place of Dea | | | | | |
| 1: To | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 1 ☐ Inpat | iury 2 | 8b. Time of | DOA 28c. In | 4 LI Nursing H | | dence 6 Ott how injury occur | | | BIICK |
| Certification: | 1 Naturei 5 Pending 2 Accident investigal | APKII 10 | 1999 F | ound 1:52 | | ork? □ Yes 2\\ No | | FELL, STR | | | |
| T E | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | 28e. Place of le building, e | njury - At hometc. (Specify) | 9 | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| cal Ce | 29a. Certifier 1 Certifying | Physician: To the bes | TREET | edge, death oc | curred at the | time, date and place | , and due to the | FOLK AVE. | annar as si | tated. | |
| Medical | one) X | aminer: On the basis and manner s | stated. | II BUILD OF STV8S | | | ान्य वर प्राप्त रातान, | | | | •/ |
| | 29b. Signature and title of certifier | King. | us | | | o.C.M.E. | | April | | | 1 |
| State | 30. Name and address of person with the DNS NE M. K. 31. Date filed (Month, Day, Year) | H | death (Item 2 | 1 | 11 Pen | n Street, | Baltimo | ore, Mar | yland | 1 2120 | 1 |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Lest) Month Yeer COVERT 9:10 AM FRANK THEODORE APRIL 22 1999 4c. County of Death 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL CENTER HARBOR 8. Date of Birth 8. Date of Birth 9. Birthpleca (State or Foreign Month, Day, Year 926 Mary and If Under 24 Hrs. Hours Min. 6. Sex 1 M 2 □ F If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Days 220-20-5685 Usual Residence of Decedent Months Yrs 10d. Inside City Limits 10e State 10h Count 10c. City. Town or Location 1 Yes 2 □ No more Mary land 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code nada 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Yes 2 2 □ No 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify 18 Merican American 16b. Kind of Business/Industry 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working / life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) supervisor Socia d 18. Mothers Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) DUPT ant (daughter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Neme/Reletionship (Type, Print) S 13100 Impe 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 Cremetion rison 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signeture of Funeral Service Licensee osep S W. North Ave. Balto. the seese, or complications that caused the death. Do not enter the mode of dying, such Approximate Intervet Between Onset end Deeth Immediate Ceuse (Finel SEPSIS WEEKS disease or condition resulting in deeth) Due to (or es e consequence of): ABCESS INTRA-ABDOMINAL MONTH ONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequenca ot): Due to (or as e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy INFLAMMATORY BONIEL DISEASE SPINAL 2 No CERVICAL STENOSIS 1 ☐ Yes 2 ☐ No CORD 1 Yes 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 SNaturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29a, Cartifier (Check only one)

Examiner physician end the bunal-transit The law requires that the death certificate be executed been signed by the a should be detached is cartificata has t director, page 2 s

Physician /Medical

Examiner

Physician/Medicai

þ

Completed

Be

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Certification:

edical

Physician

/Medical

Examiner

Directo

by Funeral

Completed

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial hygiana. Important: if item 27 is marked other than "nature!" any injury or other traumetic exercises.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours efter death.

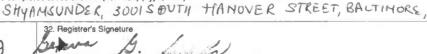
To the Funeral Director: After this cartifica complataly filled in by the funeral director; p

> State Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

ARCHANA K



K. Shammoler,

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

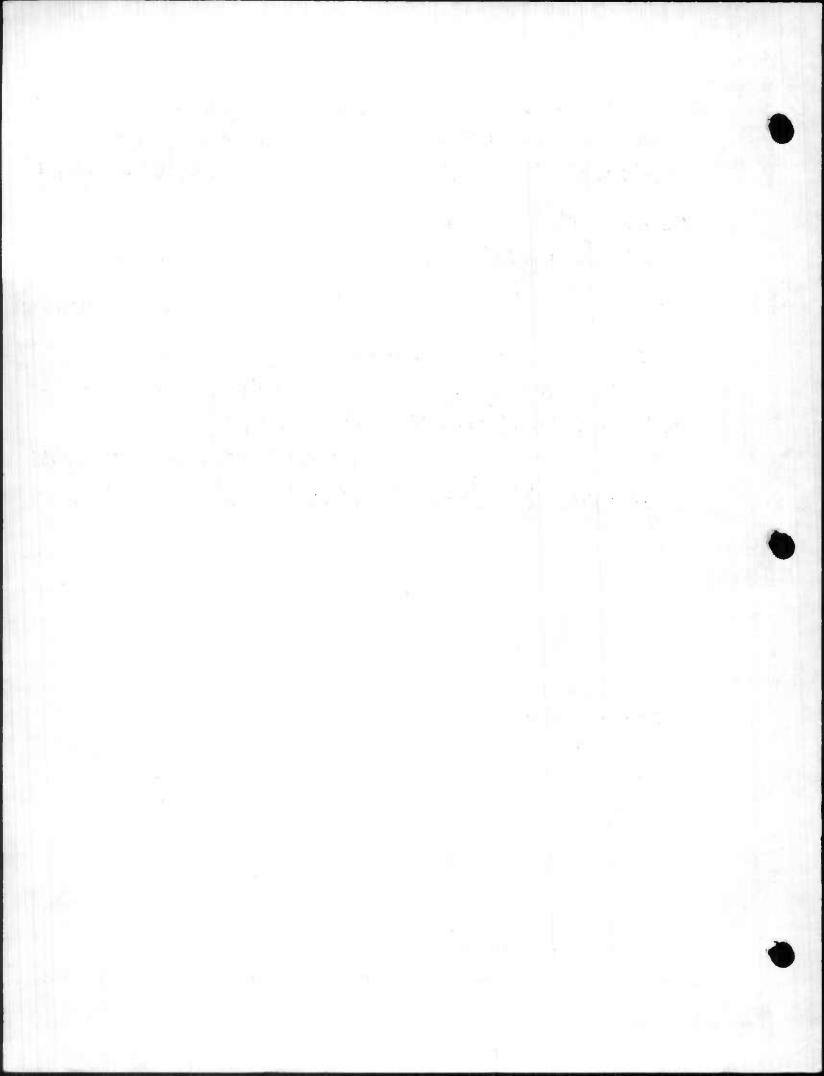
KES 000

29d. Date eigned (Month, Dey, Year)

1999

APRIL

DHMH 16 Ray 6/95



State Registrar **DHMH 16 Rev 6/95**

within 2 To the To the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
> (HARUMEHTA, ND 8775 cland leafs at to 224, columbia. MD 21045. 31. Dete filed (Month, Day, Year) APR 23 1999

29b. Signeture end title of certifier

efueltarios

29a. Certifier

(Check only one)

82. Registrer's Signeture

Dacks

12 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

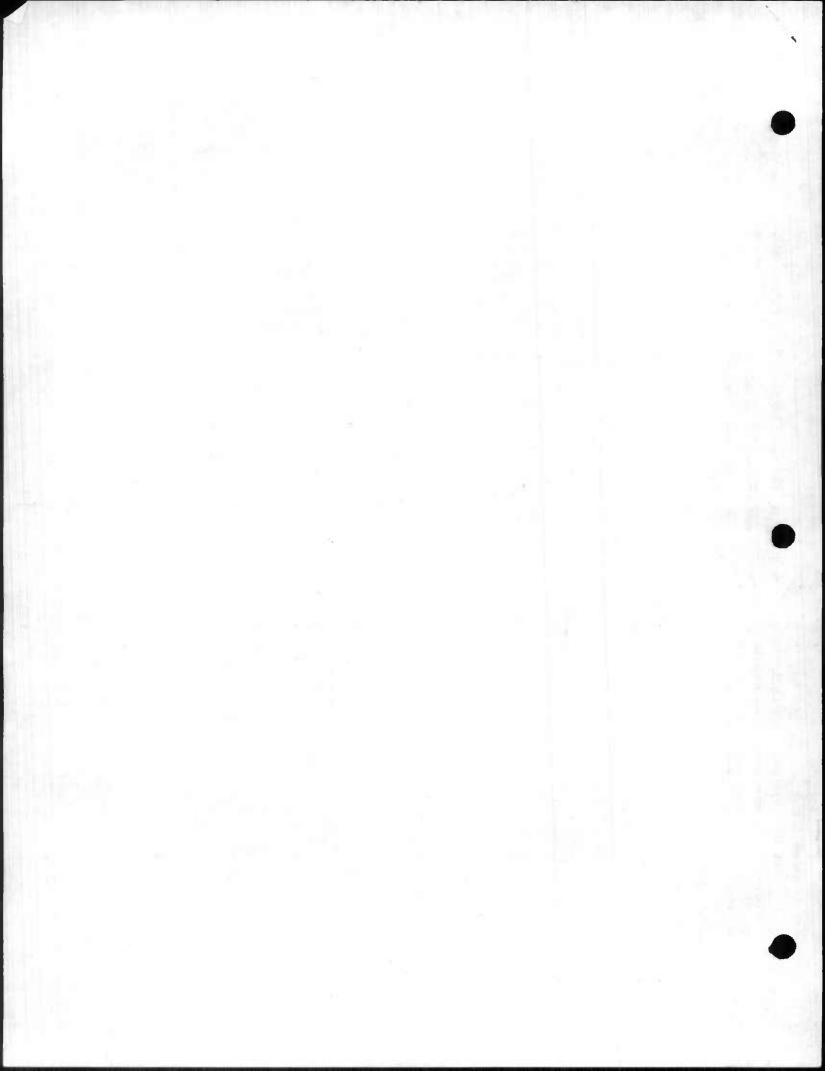
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

D34974

29d. Dete signed (Month, Day, Year)

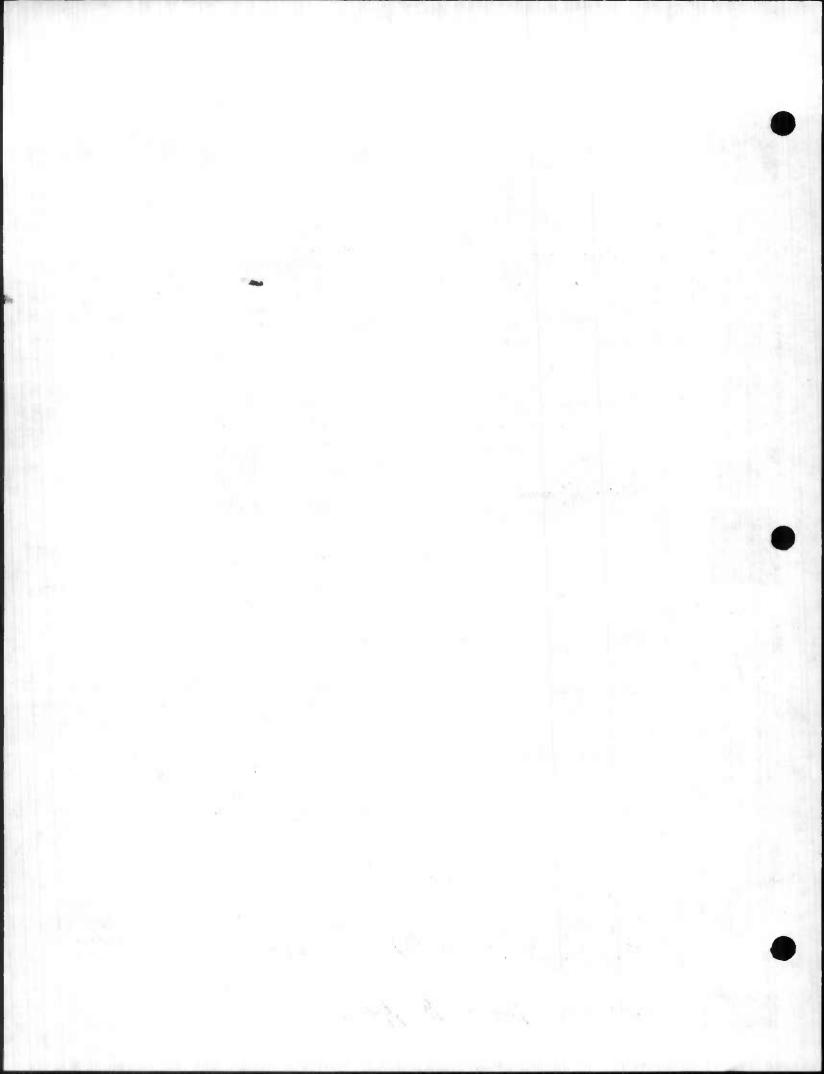
April 21st 1999.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 1 3 3 3 4

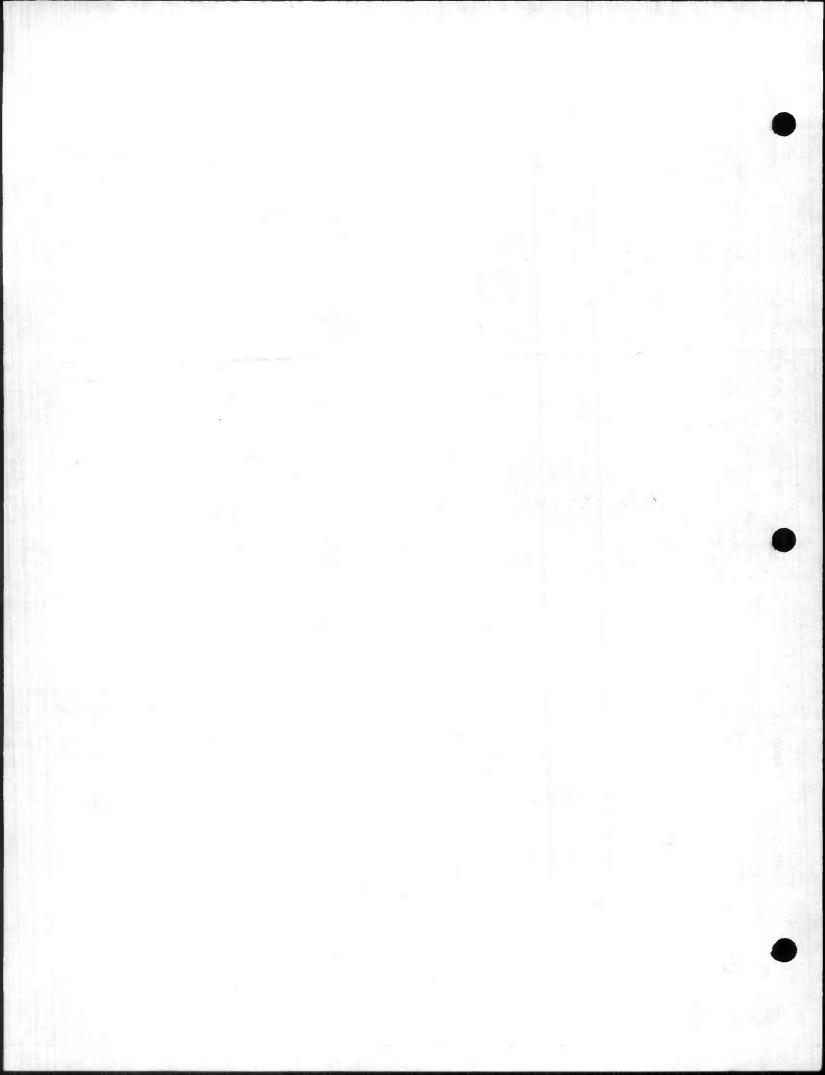
| | | | | Cert | tificate of | Death | | Re | g. No. | | | | |
|--------------|--|--|--|---------------|--------------------------------------|-----------------------------|---------------------|----------------------------------|---------------------------------|-----------------------|--|--|--|
| | | 1. Decedent's Nama (First, Middla, Last) | | | | | | 2. Date of Death | 1 | | 3. Time of Death | | |
| | Physician | LOUIS GABRIEL CON | NOR. SR. | | | | | April 19 | Day 1999 | Year | 1:20 A.M. | | |
| | /Medical Examiner | 4a Facility Nama (If not institution, giva street | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. County | of Death | 1.40 A.H. | | |
| 4 | Examiner | 1010 Jamieson Road | | | | Luthe | rui 1 | 10 | Bolti | mara | County | | |
| 1 | - Comment | 5. Social Security Number 6. Sax | 7. Aga (In yrs. last | t birthday) | If Undar 1 Year | | | 8. Data of Birth | | | laca (Stata or Foreign | | |
| П | Funeral Director | 218-18-1948 ¹ MM | | Yrs. | Months Days | Hours | Min. | (Month, Day, June 2.7 | | | zland | | |
| | 9 . | Usual Rasidence of Decedant | | | | | | | | | | | |
| | apple of the second | 10e. Stata 10b. County | | Town or Loc | | | | | | 11 | Od. Inside City Limits | | |
| | cto dille | Maryland Baltimore (| County | uther | ville | | | | 1 ☐ Yes 2 No | | | | |
| | or 28a4 s be notified Director | 10e. Street and Number | | | 10f. Zip Coda | | | 10 | g. Citizen of W | that Coun | try? | | |
| | 4 23 E | 1010 Jamieson Road | | | | .093 | | | USA | | | | |
| | her death with the Maryla r herre 23e or 28e-f show sher, must be notified at Furneral Director | | Was Decedanf Evar in U,S. Armed Forcas? | 13. W | as Decedant of I Yas, specify Cub | Hispanic Ori an, Maxicar | igin? (Spen, Puarto | ecify Yes or No- Rican, atc.) | | - Amaric k, White, | | | |
| 020 | er, or | 2.5 | I⊠Yas 2□No If¥ès, Giva Yaar or Datas: '41-'4 | 1 | ☐ Yas 2 No | | | | Specify: | Whit | е | | |
| 21215-0020 | od within 72 ho ygiene. er than "natur 4. the Medical. Completed | 15. Decedent's Education (Specify only highest grade continue) | | (Giva k | ent's Usual Occup | during mos | it of worki | ing 1 | 6b. Kind of Bu | sinass/Inc | lustry | | |
| 2 | The Man | | College (1-4or 5+) | lifa. D | O NOT usa retire | d) | | | | | | | |
| 2 | Col It Ib | | 1 yr | Tra | vel Agen | | | | | | rtainment | | |
| Maryland | Be some | 17. Fathar's Nama (First, Middla, Last) | | | | 18. Moths | ars Nama | i (First, Middle, M | (First, Middle, Maiden Surnama) | | | | |
| yla | Men Men To | John Stephen Connor. | | | | | | retta Mc | | | | | |
| A | di and | 19a. Informant's Name/Ralationship (Type, | Print) | 19b. Mailing | Addrass (Street | and Number | er or Rura | il Routa Number, | City or Town, | State, Zip | Code) | | |
| | and m 27 | Mary Colbert Connor | | | | Road | , Lu | thervill | | | | | |
| altimore, | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 20a. Method of Disposition 1 ☐ Burlal 2 ☒ Cramation 3 ☐ Ramo | com | | ition (Nama of atory or othar pla | ce) | İ | Data 2 | Oc. Location - | City or To | wn, Stata | | |
| E | Pag ment ant: | 4 □ Donation 5 □ Othar (Specify) | | n_Mou | nt Crema | tory | 4 | /20/99 B | altimor | e. M | arvland | | |
| a | poert poort y in | 21. Signature of Funeral Service Dicenses | | 3.6 * | nt Crema Nama and Addra | T 1 C | ty | D | ** | | | | |
| œ | 88158 | Martin D. Lawson | 21 | M1: | tchell-W | ledei | eld. | Funeral | Home, | inc. | 010 | | |
| | | Martin 23a. Part. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complete shock. | ons that caused the death. I | Do not enta | r tha mode of dyi | ng, such as | cardiac o | r respiretory arre | Marylar st, | na ZI | Approximate | | |
| 8 | Physician | SHOCK, OF HARR TRILLIFE. LIST ONLY ONE CO. | | | | | | | | 1 | Interval Between Onset and Death | | |
| 4 | /Medical | Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): Rend Cal lure Dua to (or as a consequence of): | | | | | | | | | | | |
| | Examiner | rasulting in death) a | Dua to (or as | s a consequ | ience of): | 100 | 100 | | | 1 | Incertain. | | |
| ш | i i | | Dein | 1 - | Collic | 9 | | | | 1 | 2 weeks | | |
| | rificate be executed g physician and as the burial-transit | Sequentially list conditions | Dua to (or as | s a consequ | ence of): | | | | | 1 | 0 | | |
| ó | an an an an an an an an an an an an an a | Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Cause (Disease or injury | | | | | | | | | | | |
| 68760, | ficate be physicials the bu | Cause (Disease or injury c. that initiated evants a consequenca of): Tasulting in death) Last Dua to (or as a consequenca of): | | | | | | | | | | | |
| | 2 2 5 | rasulting in death) Last | | | | | | | | | | | |
| Box | attendin I for use | d | | | | | | | | 1 | | | |
| | requires that the death certi een signed by the attending hould be detached for use a eted by Physician/M | Part ff. Other significant conditions contribu | uting to death but not resulting | ng In the unc | darlying causa gi | ven in Part I | t. | 23b. Did tol | bacco uss con | tribute to | the cause of death? | | |
| P.0 | es that the de igned by the a be detached? | | | | | | | | 1 Yes 2 No 3 Probably 4 | | | | |
| S | igned be de | | | | | | - | | ,/ | | | | |
| pro | been si should l | | | | | | | 24a. Was an | | avi | are autopsy findings ailable prior to | | |
| S | law requires been 2 shoul | | | | | | | | | COI | npletion of cause death? | | |
| Vital Record | 0 - 5 - | | | | | | | 1 ☐ Ya | s 2 No | 10 |]Yas 2□No | | |
| ta | certificate rector, pag | 25. Was casa rafarred to medical | | | | 28. Place | a of Death | (Check only one | , , | | | | |
| > | | examinar? | ital: 1 fnpatient 2 ER | VOutpatienf | 3 DOA Ott | hor | | ma 5 Rasider | | er (Snecih | v) | | |
| of | Physical derail d | 27. Manpar of Death 2 | 8a. Deta of Injury 28 | b. Tima of | 28c. fnju Wo | | - | 28d. Describe ho | | | , | | |
| lon | th. : After e fune | 1 Netural 5 Pending investigation | (Month, Day Year) | fnjury | | rk/ Yas 2∐ | No | | | | | | |
| Division | or Attending after death. Director: After d in by the fune ertification | 3 Suicida 6 Could not be | 8a. Place of Injury - At home | e, farm, stre | et, factory, offica | | | 28t. Location (Str | eet and Numbe | er or Rura | l Routa Number, | | |
| á | tal or Attending P rs after death. al Director: After t ed in by the funer: Certification: | 4 Homicide | building, etc. (Specify) | | | | | City or Town, | , Stata) | | | | |
| | hours hours y fille | 29a. Certifiar Certifying Physicia | n: To the best of my knowle On the basis of axamination | dge, deeth | occurred at the ti | ma, data an | d placa, | and dua to the ca | usa(s) and ma | nner as si | ated. | | |
| | To the Hospital or Attending I within 24 hours after death or To the Funeral Director. After completely filled in by the funeral Medical Certification | (Check only 2 Medical Examiner: one) | On the basis of axamination and menner steted. | and/or inva | astigetion, in my o | opinion, des | oth occurr | ed at the time, da | ita and place, a | and due to | the cause(s) | | |
| | Within To the Comp | 29b. Signature and title of certifier | 11/11/ | | 29c. Licens | se number | | 29 | d. Dafa signed | (Month, | Day, Year) | | |
| | | + for after Dik | 1 Krandeli | MV) | D | 155 | 23 | | 411 | 9/0 | 79 | | |
| | | 30. Nama and addrass of person who comple | eled cause of death (flem 23 | 3a) (Type, P | rint) | 100 | | | | | | | |
| P | | Robert G. Knodell, | | | | owson. | . Mar | vland 2 | 1204 | | | | |
| | State | 31. Data filed (Month, Day, Year) | 82. Registrar's Signatur | 9 | / | | | | | ~ ~ | | | |
| | Registrar | APR 2 3 1999 | Denne D | . 19 | oaks | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3336 Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:49 Crouse 4b. City, Town, or Location of Death 99 CRUIN 4a Pacility Name (If not institution, giva street and number) 4c. County of Death Lniversity Baltimore 6. Sax yland N/A Hours Min. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Aga (In yrs. last birthday) if Undar 1 Year Months Days **№** M 2□ F 25 216-98-9192 MD Usual Residence of Decedent 10b. County Baltimore 10d. Inside City Limits 10c. City, Town or Location Rosedale 1 ☐ Yes 2 No 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 8364 Pulaski Highway 21237 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 20 No if Yes, Give* Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 🎉 ☐ No Specify: Specify white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Laborer Moving & Storage 17. Father's Name (First, Middle, Last) Charles E. Crouse 18. Mother's Name (First, Middle, Maiden Sumama) Kathleen Willig 19a. Informant's Name/Relationship (Type, Print) Kathleen Dietz / mother 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 8364 Pulaski Hwy. Rosedale, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-99 Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Cvach/Rosedale Funeral Home 23a. Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cerdiac or respiratory errest, **Totale Totale Totale 1211 Chesaco Ave., Rosedale, MD shock, or heart failure. List only one cause on each line. 21237 Approximate Interval Between Onset and Death Wald to the office trumper of the second trumper of tru Intra Cramal Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Multisysten Organ 24b. Were autopsy findings availabla prior to complation of cause of death? Splenic Injury 24a. Was an autopsy 1 Yas 2 LNO 1 TVes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Driver 28b. Time of Injury ar Accident 1 Natural 5 Pending 2:45AM 1 Yes 2 No 04-13-99 investigation 2 Accident 281. Location (Street and Numbersor Rural Route Numbersor City or Town, State of the grant House Numbersor Rural Blvd. Blvd. 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sfreet, factory, office building, etc. (Specify) 4 Homicide Route 434 Pery Hall Blud - Street

and physician a s the buriel Division of Vital Records, P.O. Box 68760, signed by the cartificate this

Physician/Medical p Completed Be Certification: To

Medical

29a. Certifier

Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumstic event, the Wedical Exampler must be notified at

pamilt. Pages 1 and 2 should be filled within 72 hours effar or Department of Haalth and Mental thygiene.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

tha Marylend

daath

Hospital or Attending Physician: Aftar s efter deeth. To the Hospital or Attain within 24 hours efter der To the Funeral Director completaly filled in by the

> State Registrar

31. Date filed (Month, Day, Yaar) APR 2 3 1999

29b. Signature and title of certifier

29c. License number

of

12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted.

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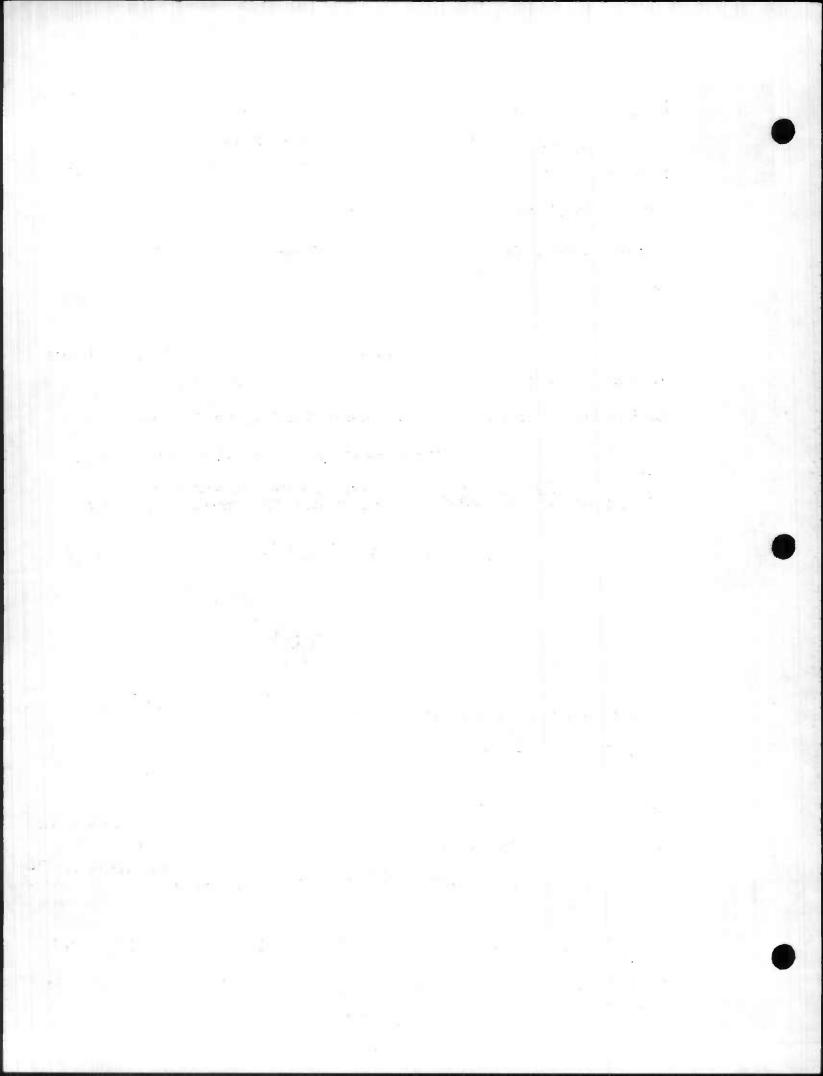
29d. Data signed (Month, Day, Year)

Shock Tram Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mak ones

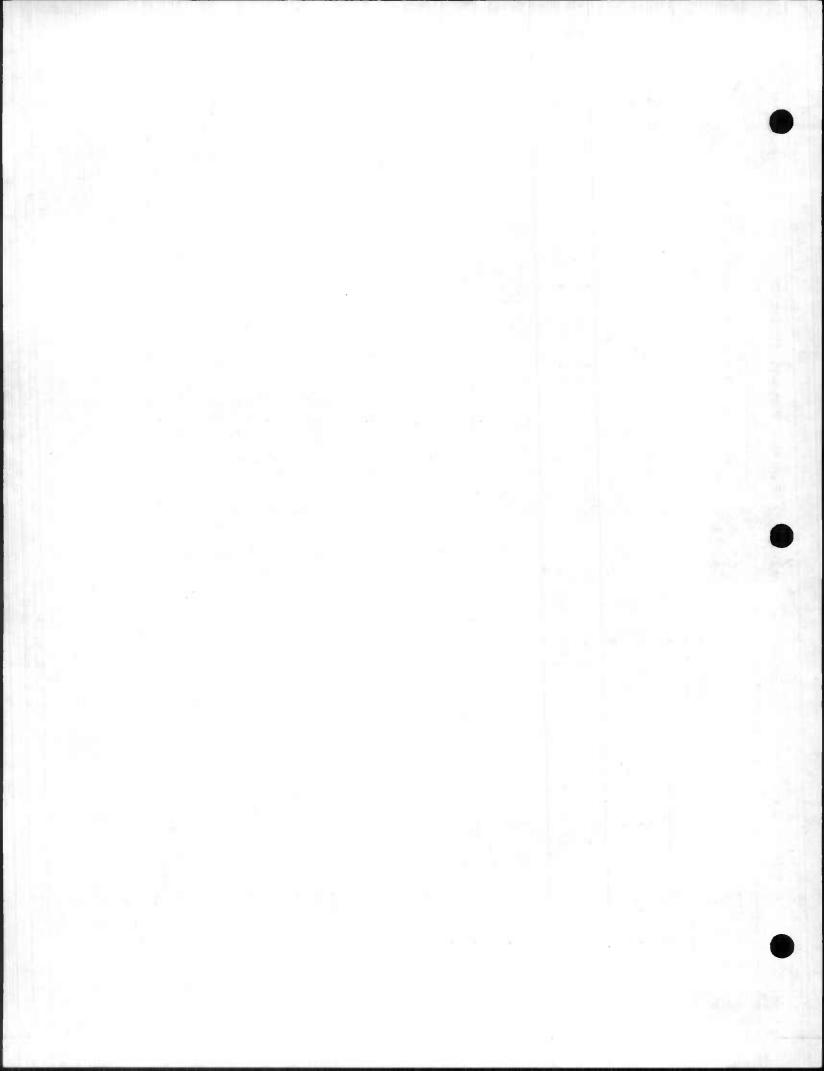
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2. Registrar's Signature



| | 1. Decedent's Na | me (First, Middle, Las | 1) | | | tificate | | | 2. Date of D | | Year | 3. Time o | Deeth | |
|---|---|--|--|--|---------------------------------|--|-----------------------|---|-----------------------------------|--|---|--------------------------------|------------|--|
| Physician /Medical | Share | on Cr | osby | | | | | | April | Dey 7 | 1999 | 12:45 | a.m | |
| Examiner | 4a Facility Name | (If not institution, give | street and number |) | | | 4 | 4b. City, Town, or | Location of Dea | th 4c. County | of Death | | | |
| | | West Drive | | | | Milledge | | Edgewate | | | Aru | | | |
| Funeral Director | 5. Social Security 212 52 Usual Residence | 4632 | 0X 7. A | ge (In yrs. 1 | ast birthday) Yrs. | If Under Months | Days | Hours Min. | 8. Dete of Bi (Month, D | | 1 | place (Stete ntry) yland | or Foreign | |
| deeth with the Maryland ms 23s or 28s-f show rms the notified at neral Director | 10a. Stete | 10b. County | | 10c. City | , Town or Lo | cation | | | | | | 10d. Inside (| ity Limits | |
| vith the Me or 28s-f a be notified Director | MD | Anne Aru | indel | Edo | ewate | r | | | | | | 1 🗆 Ya | 2 No | |
| or 24 | 10e. Street and N | umber | | | | 10f. Zip | Code | | | 10g. Citizen of | What Cou | ntry? | | |
| eth w | | t Drive | | | | | 037 | | | USA | | | | |
| urs efter ur, or the harmon by Fur | | rried 2 (X Merried 4 Divorced | 12. Wes Decedent Armed Forces 1 Yes 2 K If Yes, Give Year or Dates: | ? | | | | lispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or N o Rican, etc.) | | ck, White, | | | |
| ed within 72 hours ygiene. her then "netural; rt, the Medical Ex Completed by | (So | 15. Decedent's Ed | ucation de completed) | n 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | | | | usiness/In | dustry | | |
| within then the then the then the then the then the then the then the then the then the then the the then the then the the the then the the the the the the the the the the | Elementary/Sec | 5+) | lite. L | O NOT us | e retired | 1) | | | | | | | | |
| Hygie Hygie ant, ID CO | 17 Father's Name | e (First, Middle, Last) | | | Sec | reta | ry | 19 Mothar's Nor | na /Eiret Middle | Educ Maiden Sumai | ratio | on | | |
| Saby W | | | | | | | | | | | 110) | | | |
| ahould to marked umarked | John W | YNNE Neme/Relationship (7 | ivne Print) | | 19h Meilin | n Address | (Street | Viola and Number or Re | | | State Zir | n Code) | | |
| end 2 sho saith and n 27 ie m er traum | | P. Cros | | (Hus | | | | | | | | | | |
| f Head office of the | 20a. Method of Di | isposition | | 20b. P | lace of Dispo | sition (Nan | ne of | | Dete | 20c. Location | | | | |
| Pege nt: H o | 1 🖾 Burial 2 | 2 Cremetion 3 C | Removel from State | 9 | 100 100 | | | | 04/09 | Crowns | svi 1 i | 10. N | D | |
| permit. Peges 1 and Department of Health Important: If item 27 any injury or other tr phice. | 4 Donation 5 Other (Specify) Maryland Veterans Cem. 04/0 21. Signature of Funda Service Licenses 22. Name and Address of Facility | | | | | | | | 04/03 | CLOWITS | OVII. | ie, r | D | |
| Pen impo | 100 | Truk 1 | L Man | 11 | (Ha | rdes | ty | Funeral | Home | P.A. | | | | |
| | 23a. Pert1. Enter | r the disease, or compount tailure. List only co | lications that cause | d the death | Do not ente | Rid or the mode | gel e of dyin | y Ave. | Annapo or respiretory | olis, Narrest, | 1D 2 | 1401 Approxima | te | |
| Physician | shock, or he | eart tailure. List only o | ne cause on each | ine. | | | | | | | | Onset end | Deeth | |
| /Medical | Immediete Cause diseasa or condit | e (Finat | Cardi | o res | pirato | ry ar | res | t | | | 1 | | | |
| Examiner | resulting in deeth |) | a | Due to (o | r as a conseq | uence of): | | | | | | | | |
| P # L | | | h Pneum | onia | | | | | | | | 4 day | S | |
| and trans | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Disseminated pancreatic cancer | | | | | | | | | | | | | |
| ocian do ex | cause. Enter Und | derlying or injury | Disse | minat | ed pan | creat | cic | cancer | | | 1 | 6 mor | ths | |
| ificate be secured g physician and as the burtal-transit edical Examiner | that initieted even resulting in death | its | | Due to (or | as a consequ | uence of): | | | | | | | 5 11 | |
| = 00 = 1 | | | d | | | | | | | | i | | | |
| death of attended for u | | | | | | | | | | | 1 | | | |
| d by the ettendin etached for use Physician/M | Part II. Other sign | ificant conditions co | ntributing to death I | but not resu | ilting in the ur | derlying ca | ause giv | ren in Pert f. | | tobacco use co | 1 1 1 1 1 | | of death | |
| igned be deta | | | | | | | | | 11 | Yes 2□ No | 3∐ Pro | bably 4£ | Unknow | |
| requires that the een signed by th hould be detache sted by Phys | | | | | | | | | 24a. We | s en eutopsy | 24b. W | era autopsy | findings | |
| > 00 | | | | | | | | | pen | formed? | CC | vailable prior of death? | cause | |
| | | | | | | | | | 10 | Yes 20 No | 1 | □Yes 2 | Š No | |
| e he mo | 25. Wes case refe | erred to medical | | | | | | 26. Place of De | | | | | | |
| en de page | | No T | Hospital: | ient 2 🗆 | ER/Outpatien | 1 3□ DO | Oth | | | sidence 6 Ot | her (Speci | (v) | | |
| relcian: The lev s certificate has director, page 2 o Be Comp | examiner? | a the | 28a. Date of Inj (Month, D | | 28b. Time of Injury | | 8c. Injur Wor | | | how injury occu | | ,, | | |
| yalcian: is certific director | 1 ☐ Yes 22 27. Manner of Dec | | | | 20/05/1 | М | 1 🗆 | Yes 2□No | | | | | | |
| yalcian: is certific director | 1 ☐ Yes 2 2 27. Manner of Dec 1 Ø Neturaf 2 ☐ Accident | 5 Pending investigation | | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | | | | | ffice 28f. Location (Street and Number or Rural Route Numb City or Town, State) | | | |
| yalcian: is certific director | 1 Yes 20 27. Manner of Dec 1 Wheturaf 2 Accident 3 Suicide | 5 Pending investigation 6 Could not be | 286. Place of In | jury - At ho | me, term, stri ') | ot, ractory | , 011100 | | | | | ai Houte Nu | 11001, | |
| v Attending Physician: free death. freetor: After this certific in by the funeral director. rtification: To Be | 1 Yes 2 27. Manner of Dei 1 XX Neturaf 2 Accident 3 Suicide 4 Homicide | 5 Pending investigation 6 Could not be | 286. Place of In | ijury - At ho lc. <i>(Specif</i> y | me, term, str | ot, ractory | , 0.1100 | | | | | ar Houte Nu | | |
| v Attending Physician: free death. freetor: After this certific in by the funeral director. rtification: To Be | 1 Yes 2 2 2 2 27. Manner of Dei 1 W Neturaf 2 Accident 3 Suicide 4 Homicide | 5 Pending investigation 6 Could not be | building, e | of my know | vledge, deeth | occurred (| et the tir | | City or To | own, Stete) cause(s) end m | enner as s | stated. | | |
| v Attending Physician: free death. freetor: After this certific in by the funeral director. rtification: To Be | 1 Yes 22 27. Manner of Dec 1 Wheturaf 2 Accident 3 Suicide 4 Homicide | 5 Pending investigation 6 Could not be determined | building, e | of my know | vledge, deeth | occurred a | et the tir in my o | pinion, deeth occu | City or To | own, Stete) e cause(s) end m , date end place, | enner as s | stated. to the cause | | |
| The Hospital or Attending Physician: In 24 hours after death. In Euneral Director: After this certification pletely filled in by the funeral director. edical Certification: To Be | 1 Yes 22 27. Manner of Dec 1 Wheturaf 2 Accident 3 Suicide 4 Homicide | 5 Pending investigation 6 Could not be determined | 28e. Place of in building, e sician: To the best iner: On the basis of and manner's | of my know of examinat teted. | vledge, deeth ion and/or inv | occurred a estigetion, | et the tir in my o | pinion, deeth occu | City or To | e cause(s) end m date end place, | enner as a and due t | stated. to the cause | | |
| v Attending Physician: free death. freetor: After this certific in by the funeral director. rtification: To Be | 1 Yes 22 27. Manner of Dec 1 Wheturaf 2 Accident 3 Suicide 4 Homicide 29. Contiller Check on yes | 5 ☐ Pending investigation 6 ☐ Could not be determined 1反 Certifying Phy 2 ☐ Medical Exami | 296. Place of it building, e building. e building. e building. e building. E b | of my know of examinat teted. | viedge, deeth ion and/or inv | occurred a sestigetion, | et the tir in my o | pinion, deeth occu | City or To | own, Stete) e cause(s) end m , date end place, | enner as a and due t | stated. to the cause | | |
| v Attending Physician: free death. freetor: After this certific in by the funeral director rtification: To Be | 1 Yes 2 2 27. Manner of Der 1 M Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check onloces) 20b. Signifiums and 3 december 2 | 5 Pending investigation 6 Could not be determined | sician: To the bestiner: On the basis and manner s | of my know of examinat teted. | wledge, death ion and/or inv | occurred a estigation, 29c I Print) | et the tir in my o | e number | city or To | e cause(s) end m date end place, | enner as a and due t | stated. to the cause | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month 747 JOHN DENSMORE PRIL 20 on 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death PHUDAUSTOWN BALTIMONE HOSPITAL CENTER NONTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) JAN 19, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days Months Hours 1 M 2 □ F 64 Maryland 220-30-0418 Usual Rasidanca of Dacedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Maryland Baltimore Hebbville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3232 N. Rolling Road 21244 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 X Nevar Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 n/a Metal worker Container manufacturer 18. Mother's Nama (First, Middle, Maiden Sumama) 17 Fathar's Nama (First Middle Last) Alexander Densmore Grace Virginia Farraday 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21113 19a. Informant's Name/Reletionship (Type, Print) 2441 Blue Spring Ct. unit 203, Odenton, Maryland Simone Carol Daukzsewicz(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State APR.23 4 ☐ Donation 5 ☐ Othar (Specify) Lake View Memorial Park Eldersburg, Maryland 22 Name and Address of Facility
Loring Byers Funeral Directors, Inc. 21. Signatura of Funaral Service License Mucosoy 8728 Liberty Rd. Randallstown, Maryland 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disaesa or condition rasulting in daath) stolic Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last Due to (or as e consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Hiknown OBSTRUCTIOE DISTASA 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 DNo 1 Yas 2 No 26. Place of Death (Check only one) Hospitet: 1 Dimpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner Examiner physician and the burial-transit 55x 68760 Physician/Medical 980 ed by the a O 9 Records, by Completed of Vital Be 70 this Certification: Division Attending n 24 hours after death.

• Funeral Director: A pletely filled in by the for death. ò edical

Physician

/Medical

Examiner

Funeral

Director

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s 1 and 2 should be fill I Health and Mental H tem 27 Is marked oth

Pages

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permit. Page Department of Important: If any Injury or once.

Physician

the Medical

Maryland 21215-0020

Baltimore.

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Funeral

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHROXYSMAL 25. Was case referred to medical axaminar?
1 Yes 2 100 27. Manner of Deeth 1 Neturat 2 Accident 3 Suicide 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 29a. Cartifiar 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.

29c. License number

19502

Nontepwes?

29d. Data signed (Month, Day, Year)

HESPITHE

State Registrar

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifia

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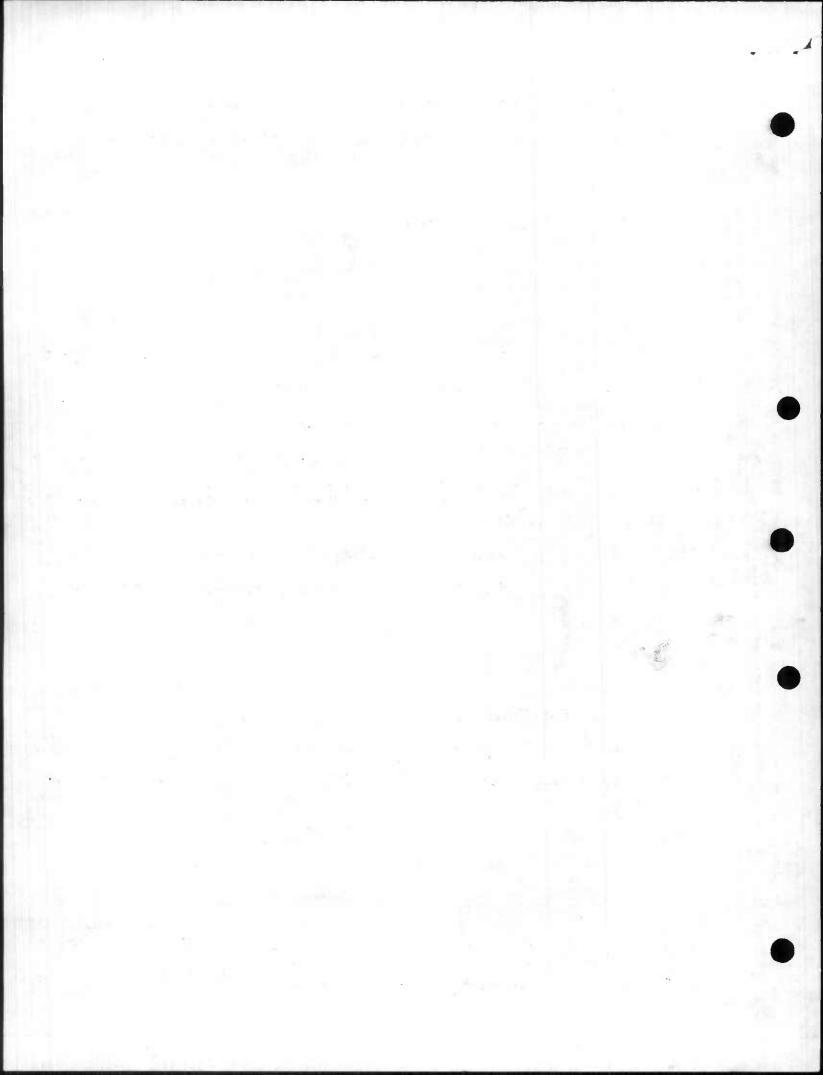
(Check only one)

B. CONTURD 32. Registrar's Signature

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

ANDALLS TOWN

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Day 1999 April Rose Philomena Dunworth 21, 2:15 PM 4b. City, Town, or Location of Death 4c. County of Death

Funeral

Physician

/Medical

Director

Funeral

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Completed

Examiner

Director with the Maryland 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examination must be inclined at daath

permit. Pagas 1 and 2 should be filed within 72 hours aftar to Deperment of Hashin and Mentel Hygiena.
Important: If Item 27 is marked other than "natural", or item any injury or other transment.

Saltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

Physician /Medical Examiner be executed ng physician and as the buriel-transit attending physician Physician/Medicai for by signed b þ should Completed peen Tha law has paga 2 cartificata To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this cartified Be To Certification: tha f in by t Medical

4e. Facility Name (If not institution, give street and number) Keswick Multi-Care Center Baltimore N/A 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) if Undar 1 Year 8. Deta of Birth (Month, Day, 9. Birthpiace (Steta or Foreign Days 1□ M 2X F Hours December 12, 1917 217-05-6232 81 Vre Baltimore, Maryland Usual Rasidance of Decedant 10a Steta 10b. Count 10c. City, Town or Location 10d. fnsida City Limits 1 Yas 2 □ No N/A Maryland Baltimore 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 700 West 40th Street 21211-2104 United States of America 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ∑ No if Yas, Giva Yeer or Datas: 14. Race - American Indian, Black, Whita, atc. 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxicen, Puarto Ricen, etc.) 1 Navar Merriad 2 Married 1 Yas 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry College (1-4or 5+) N/a Elementary/Secondary (0-12) 08 Home Maker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) George John Heinlein Anna Kaiser 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19425 Gunpowder Road Millers, Maryland 21102-2606 Mrs. Elizabeth D. Crouse(Daughter) 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Parkwood Cemetery 4/24/1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funarai Sarvice Licenses, Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 air e, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Intarvai Betwaan Onset and Death Immadiata Cause (Final Spiratory disaasa or condition rasulting in daath) Due to (or es e consequenca of) ARTURITIS STAGE HOUMATOID Sequantially list conditions, if any, laading to immediata ceuse. Entar Underlying Cause (Disaase or injury that initieted avants rasulting in deeth) Last Due to (or as a consequance of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarrad to medical 26. Place of Death (Check only ona)

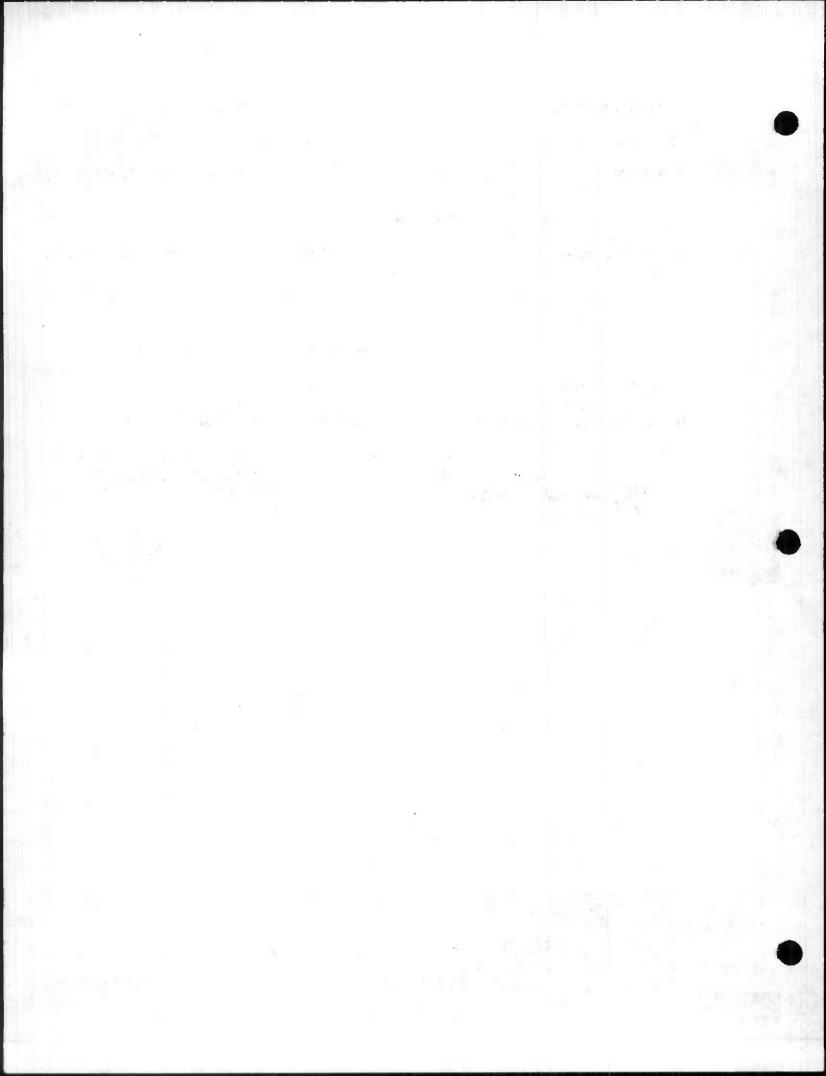
Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding investigation 142 Natural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date end plece, and dua to tha cause(s) end menner as steted.
2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurred at the tima, dete end place, end due to the cause(s) and menner stated. (Check only one) 29b. Signature and 29c. Licansa number

ceusa of death (Item 23a) (Type, Print)

29d. Deta signed (Month, Day, Year)

GREENSPILIC Ave, Suite 300, BACTO, MS 21211 390

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician Betsy Judy Grathwohl Dorsey 8:45 PM 1999 April 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7125-B Rolling Bend Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2\ F Yrs 213-60-3551 50 November 20 1948 New York Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location tOd. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore Directo 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or Items 23s or the Medical Examiner must be 7125-B Rolling Bend Road 21244 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementery/Secondary (0-12) College (1-4or 5+) Communicator/Sales Hospitality permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Hollis Williamson Grathwohl Blanche Geraldine Powers 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Dingle / Sister 166 E. 96th Street Apt. 15-A New York, NY 10128 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Crematory 4-24-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner 0 physician and the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 60 attending Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t d be detach Unknown 1 Tes 2 No 3 Probably þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? Completed Deen has **page 2** 2 NO 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home To 1 Yes 2 No ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA this Inneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? Certification: To the Hospital or Attending P within 24 hours after deeth.

To the Funeral Director: After it 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of trijury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Commying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. edicai 29a. Certifier ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) un d cause of death (Item 23a) (Type, Print) 30. Name and address of aupre Use em

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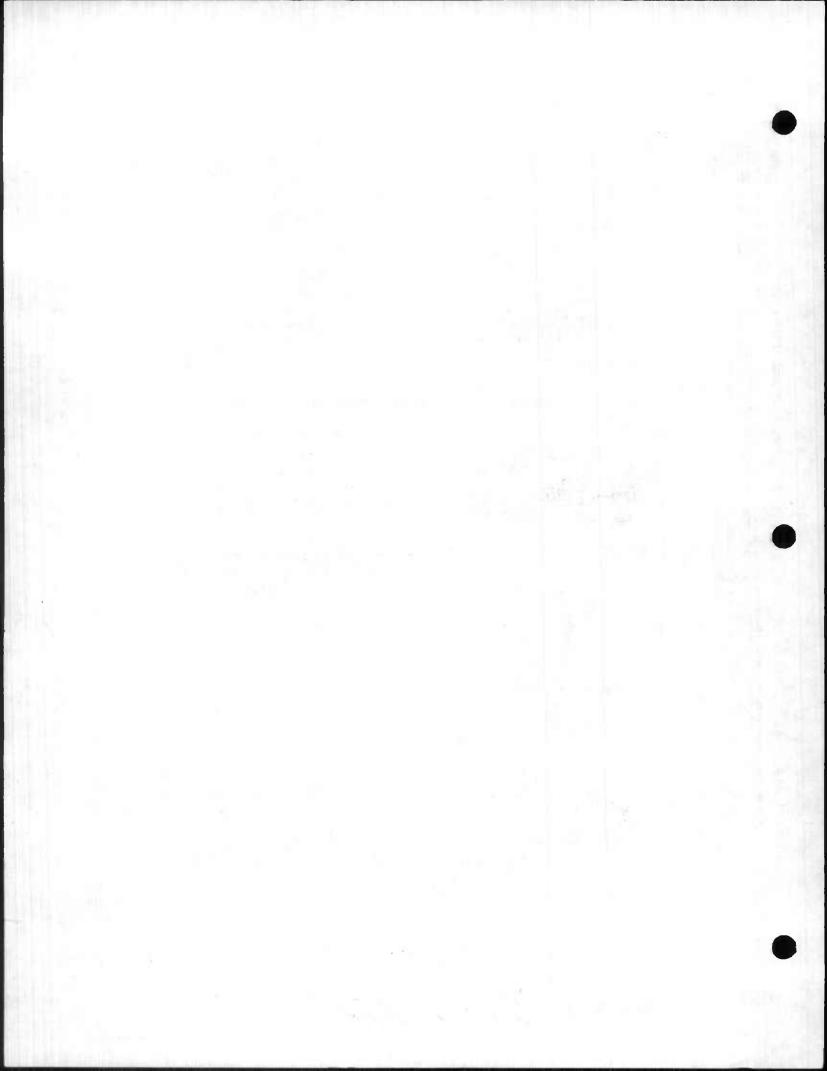
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31. Date filed (Month, Day, Year) APR 2 3 199

1999

Registrar's Signature



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾

Certificate of Death

3341

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** JOSE DAVID **ESPINAL** APRIL 21, 1999 2152 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15,1972 Dominican Repub 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours 27 076-72-0066 Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits must be notified at 1 X Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a 212 N. BELNORD AVENUE 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours efter Hygiena. Hygiena. Ther than "netural", or Itel 1 ☐ Never Married 2 ☐ Married Baltlmore, Maryland 21215-0020 DOMINICAN REPUBLICAN Specify: HISPANIC p 3 ☐ Widowed 4 🌣 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filed wit.
Department of Heelth and Meniel hygiens important: if them 27 is marked other the eny injury or other traumatic event, that pages. 6 CLERK GROCERY STORE 17. Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) 8 ALVERICO ESPINAL ADELINA RODRIGUEZ 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANUEL ESPINAL/BROTHER 1123 HORNERS LANE, BALTIMORE, MD. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 4/24/99 BALTIMORE, MD. 21. Signature of Funerel Service Licensee 22. Name and Address of Facility LILLY 1901 E Y & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Left Chest () and Left as /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician end s the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by 1 Yes 2 XINO 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? been si 24a. Wes an eutopsy performed? Completed 1 Ves 2□ No this certificata 1 Yes al or Attending Physicien: T s after deeth. Il Director: After this certificat ed in by the funeral director, pa 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitef: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No 2 1 ☐ Inpatient 20 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation subject shot DZO HX 1 Natural 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Duilding, etc. (Specify)

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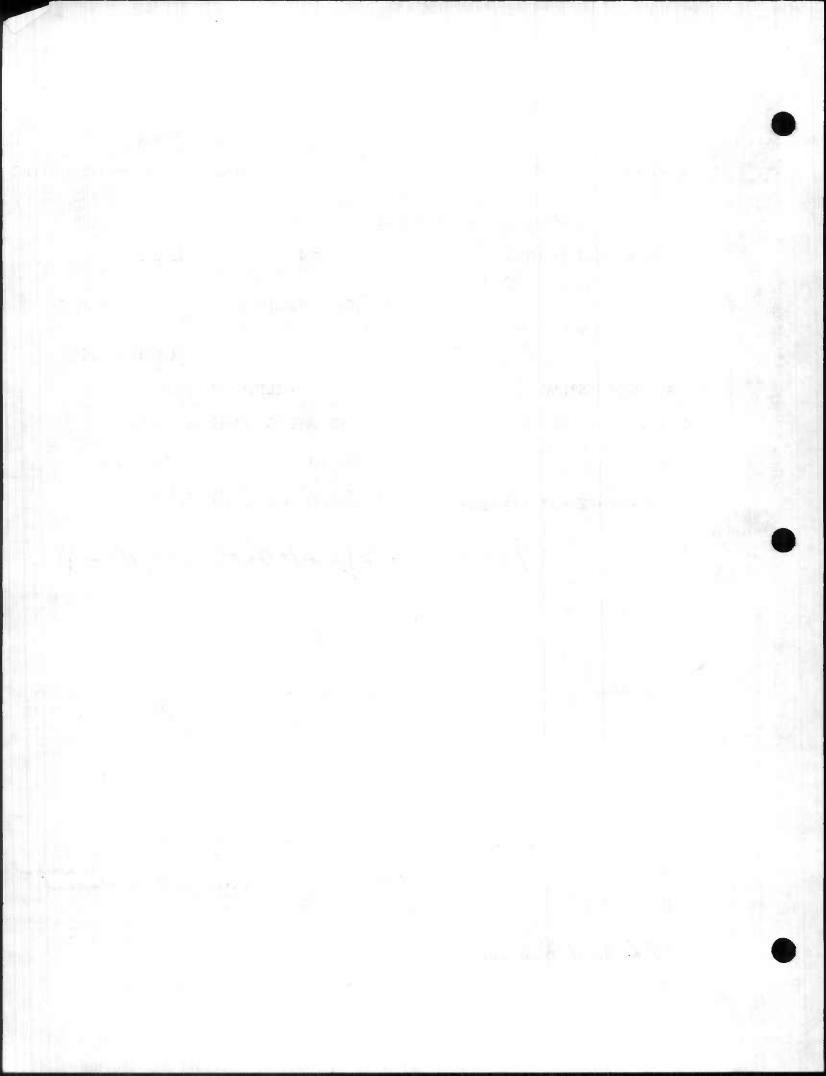
City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

XIM Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted. 4 MHomicide Kenwer To the Hospital or within 24 hours aft To the Funeral Di-completely filled in 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) APRIL 22, 1999 O.C.M.E no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THETRONE MIKEN 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

APR 23 1999



9000 Franklin Square Dr. Battimore, Maryland

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Dr. Kristin

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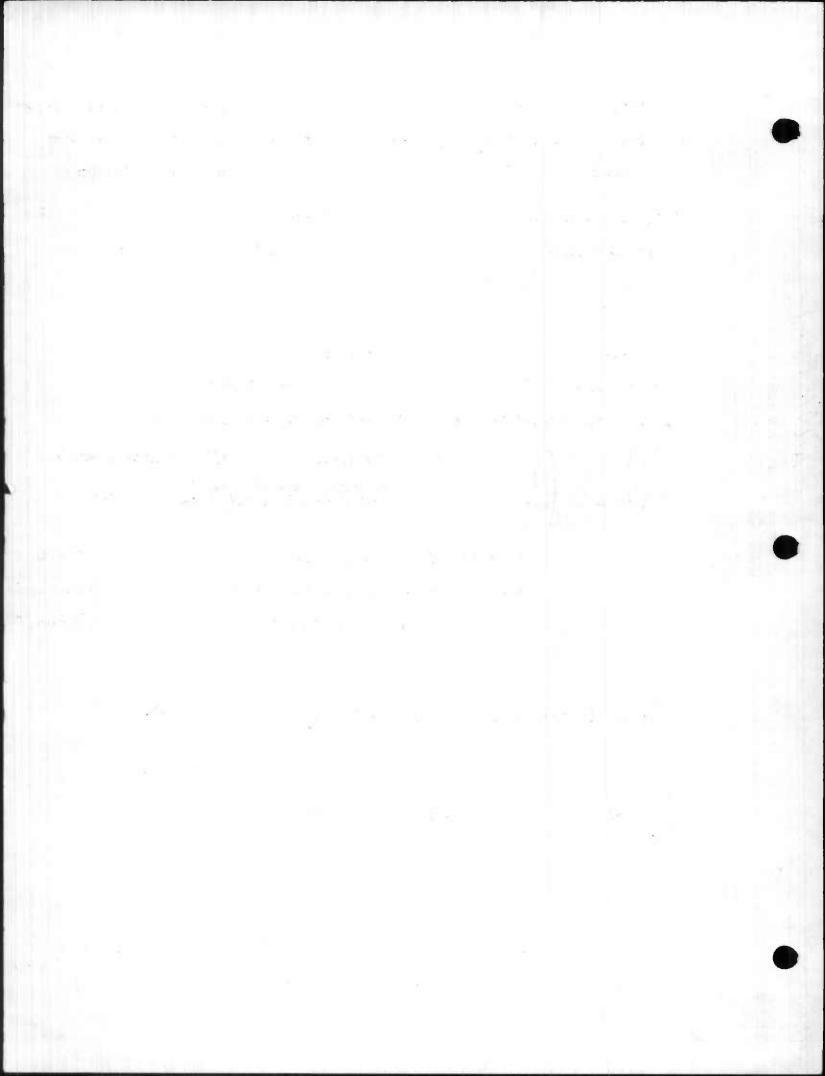
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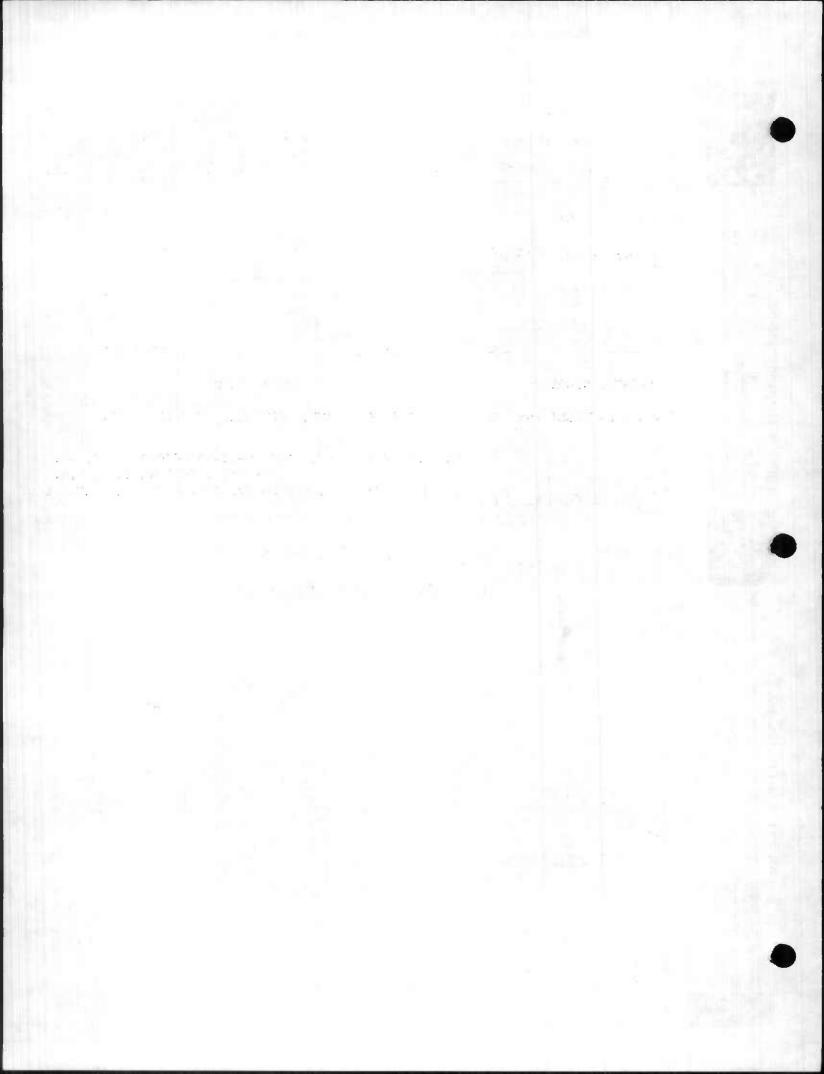
32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2252 Fosker Rosa lu Apri /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Bachmore Hospital JINAL if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10M 20F Months 218 28 7251 66 Yrs. S.C. December 1. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinat must be notified at 1 Tes 2 No Baltmore Maryland N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 54 31 (718t 21215 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Slatus 1 ☐ Yes Z☐No if Yes, Give Year or Detes: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Black ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WELDER **AEROSPACE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Lest) CLARENCE SIMPSON MAMIE BROWN 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) CAROLYN PANNELL (DAUGHTER) 5431 GIST AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State GARRISON FOREST VETERANS 4-22-99 OWINGS MILLS, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medicai **Examiner** Examiner attanding physician and for usa as tha bunal-transit requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen paga 2 s cartificata has 1 ☐ Yes 2 1 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To this funaral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of Certification: Aftar 1 PNetural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best ot my knowledge, death occurred at the time, dete and plece, and due to tha causa(s) and manner as staled. Medical complately 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. Licansa number 735 037 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BELVEDERE BALTIMURE 2401 W. ALDEN 31. Date filed (Month, Day, Year) 32 Registrer's Signature State Registrar

BHA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3344 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth Marie Foster April 21 1999 6:30 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Long Green Center **Baltimore** N/A If Undar 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) August 2,1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours Days Months 1□ M 2XF 212-50-5012 83 Director Maryland Usual Rasidance of Decedant 10b County 10c. City, Town or Location 10d. Inside City Limits show Maryland Baltimore Towson 1 ☐ Yas 2 X No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b munt be 806 Mockingbird La. 21286 United States Berns 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status "natural", or Item indical Examiner: 72 hours after 1 ☐ Yas 2 📉 No If Yas, Giva 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: white Specify: À 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedeni's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any injury or other traumatic event Be Walter Ray Laura V. Upton 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 319 Worthington Rd. Stuart Foster/son Towson, MD 21286 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata cernatary, crematory or other place) 1 ☐ Burial 2 【Cramation 3 ☐ Removal from Stala 4/22/99 4 ☐ Donalion 5 ☐ Other (Specify) Greenmount crematory Baltimore, Maryland 22. Nama and Addrass of Facilit Mitchell-Wiedefeld Funeral Home, Inc. 21. Signatura of Funeral Service Licenses 6500 York Rd. Baltimore, MD 21212 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** tmmediata Causa (Final disaasa or condition resulting in death) /Medical Cerebrivasilen accident Examiner Dua to (or as a consequence of): Examiner 130 siclan and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): physician as the burial Box 68760 Physician/Medical Dua to (or as a consequence of): mooni P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Hiknown 3 Jonos obsess signed I Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? 2 eged 1 Yas 2 No 1 Tes 2 1 No certificate Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Tima of Hospital or Attending P
 24 hours after death.
 Funeral Director: After ti 28c. tnjury at Work? After 1 Neturat 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. License number 30. Name and address of person who complated ceusa of deeth (Item 23a) (Type, Print) 821 N. EUTAN A FINTE 308, BART- MD 21201 SHOAKE -A ... HYPHMI

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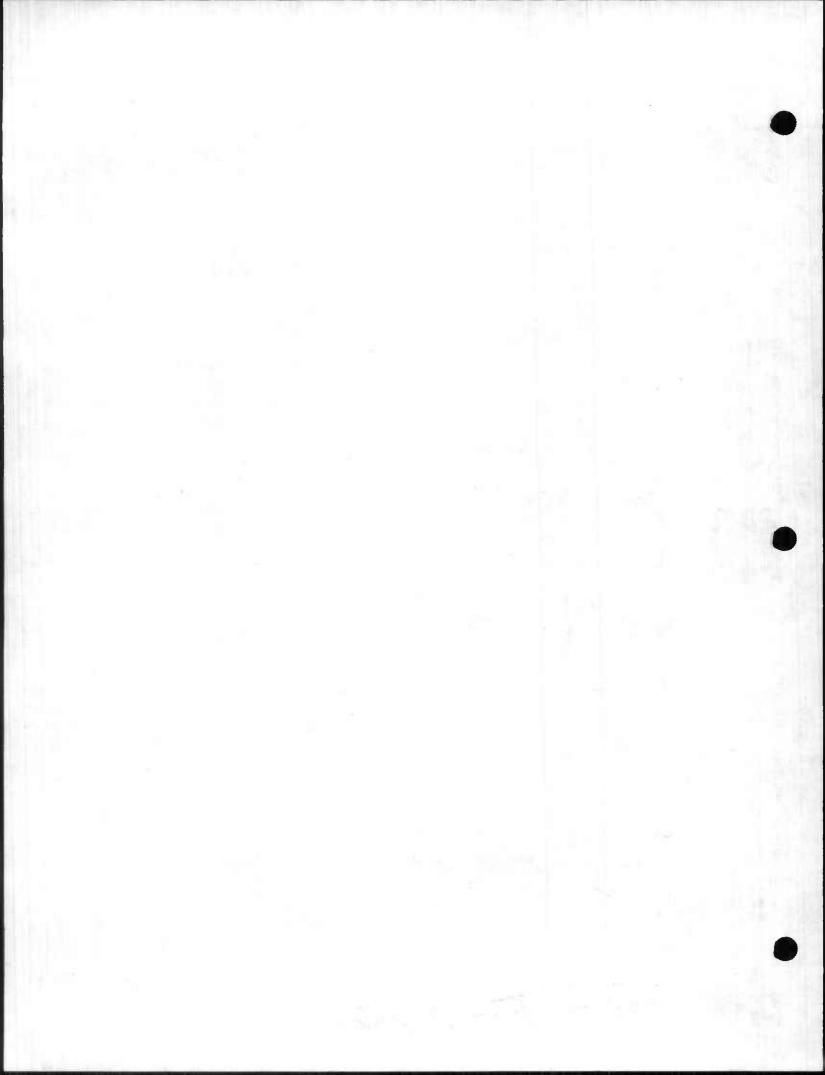
State Registrar

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Data filed (Month, Bay, Year) APR 2 3 1999 Se Registrar's Signatura

G. M.

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 19/ta Er 50 0 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 24 Hrs. If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M XXF 274-28-9041 89 Yrs. 2/8/1910 WEST VIGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits HOWARD ELLICOTT CTTY 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 DORSEY HALL DRIVE 21042 ROOM 134 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18 Mother's Name /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) **GEORGE** SCHRUMPF HANNAH (PETERS) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

"natural", or items 23s or 28s-f show

Director

Funeral

þ

Completed

the Meryland

deeth

permit. Peges 1 and 2 should be filed within 72 hours effect.
Department of Heelih and Mentel Hygiens.
Important: if Nem 27 is marked other than "natural", or hen eny injury or other treumatic event, the Hedges sections.

Baltimore, Maryland 21215-0020

The lew requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

the ettending physician and had for use as the burlei-transit Completed 8 10 After this funeral To the Hospital or Attending Pt within 24 hours effer deeth. To the Funerel Director: After th completely filled in by the funera

Deed hes

certificate

this

Physician/Medical Examiner by Certification:

edical

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

20a. Method of Disposition

WALTER FALCK (HUSBAND)

of Funeral Service Lid

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

1 SI Th Due to (or as a consequence of)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WASH. CREMATORY

22. Name and Address of Facility

5555 TWIN KNOLLS ROAD

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

20c. Location - City or Town, State

WITZKE FUNERAL HOMES, INC. COLUMBIA, MD

LAUREL, MD

21045

Approximate Interval Between Onset and Death

24a. Was an autopsy pedermed?

26. Place of Death (Check only one)

0

5330 DORSEY HALL DR RM134 ELLICOTT CITY, MD 21042

4/22/99

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No

25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 1 Attatural 5 Pending investigation

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 TYes 2 No

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29b. Signatur

29c. License number

29d. Date signed (Month, Day, Year) 9

no completed cause of death (Item 23a) (Type, Print) 170 10

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

29a. Certifier

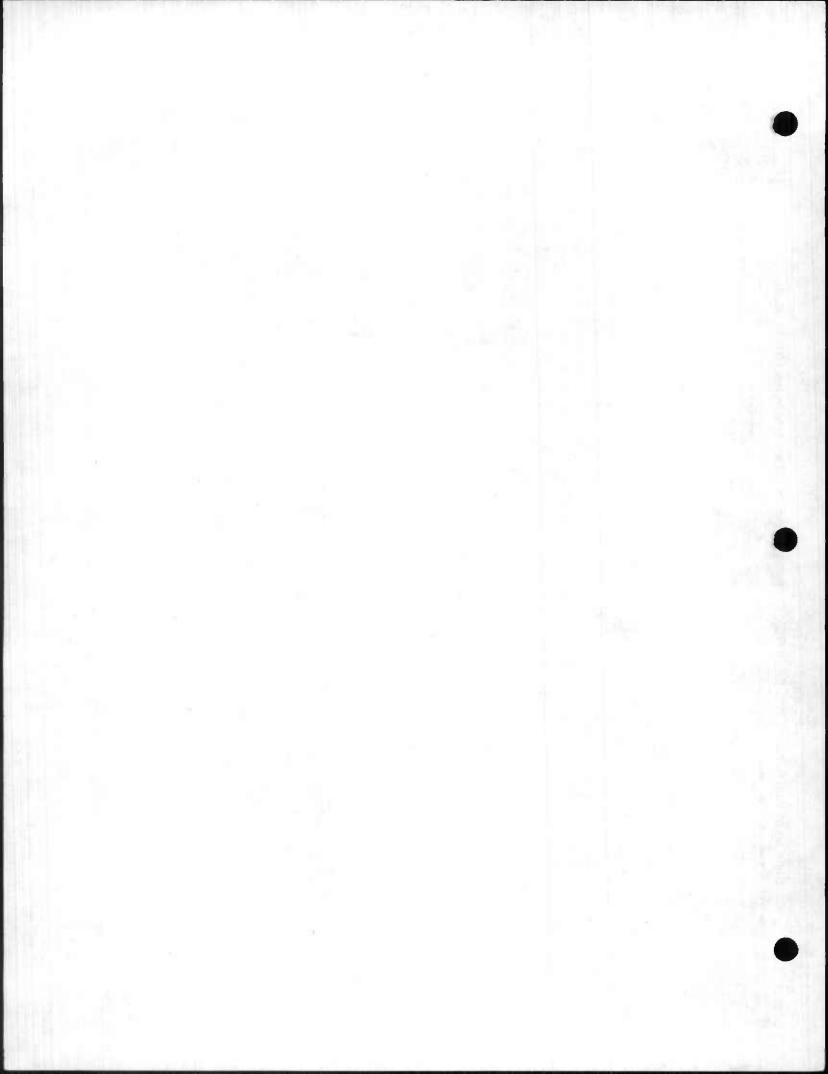
4 ☐ Homicide

(Check only

32_e Registrar's Signature

Registrar

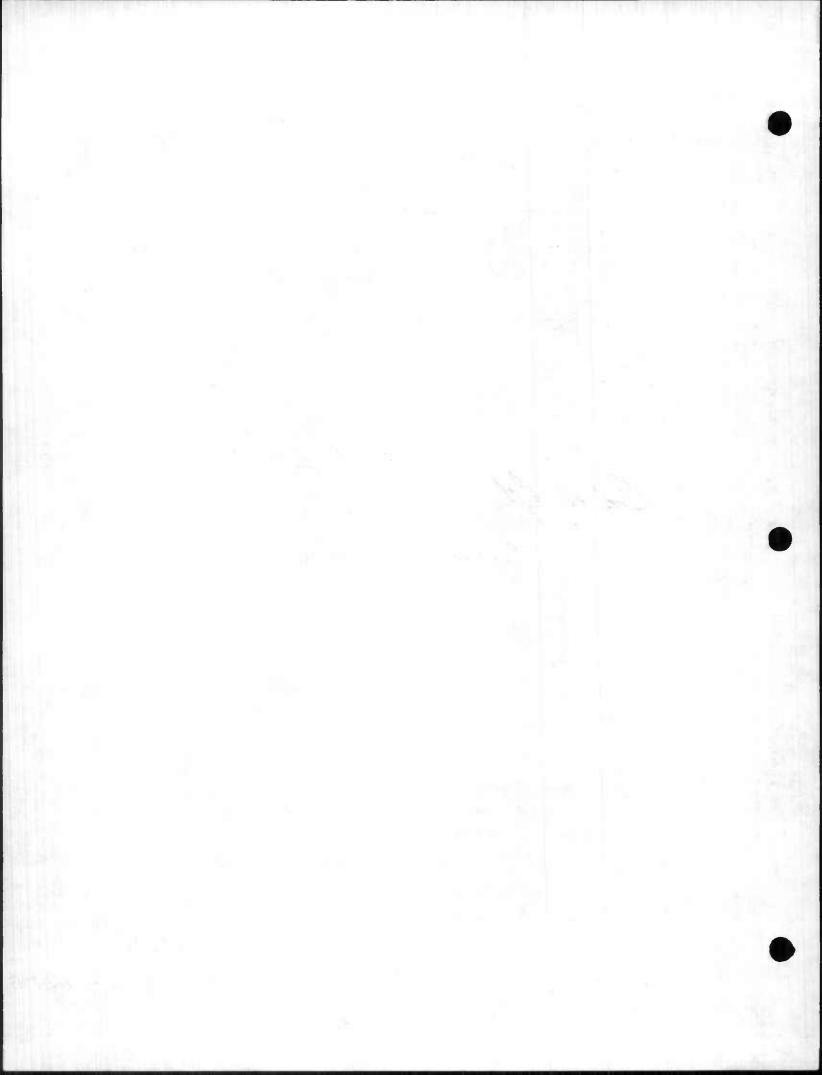
State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Ce | ertificate of | Death | R | eg. No. | 13346 | | | | |
|--|--|---|-------------------------------------|--|--|--|---|---|--|--|--|--|
| | 1. Decedent's Name (First, Middle, La | st) | 2. Dete of Dear Month | th | 3. Tima of Deeth | | | | | | | |
| Physician /Medical | Lena R. Fox | | | | | | 11 19, 1999 5:00 | | | | | |
| Examiner | 4a Facility Neme (If not institution, giv | a street and number) | | | 4b. City, Town, or i | Location of Death | 4c. County of | of Death | | | | |
| | Crofton Convales | | | | Crofton | | | Arundel | | | | |
| Funeral Director | 5. Social Security Number 216–36–9851 | 7. Age (In yi | rs. last birthday Yrs. | Months Days | | 8. Data of Birth (Month, Day 1/16/19 | of Birth h, Day, Year) 71911 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| pu . | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits | | | | | | | | | | | |
| Maryla Ma | MD Anne Ar | | 1 ☐ Yas 20 | | | | | | | | | |
| ifter death with the Mar r flems 23s or 28s-f s inter must be notified Funeral Director | 10e. Street and Number 932 Placid Cour | 1 | 0g. Citizen of W | | | | | | | | | |
| S 3 | 11. Marital Status 1 Nevar Marriad 2 Married 3X Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates: | U,S. 13. | Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☐ No | Hispanic Origin? (S pan, Mexican, Puert Specify: | pecify Yes or No- o Rican, atc.) | | - Amarican Indian, , Whita, etc. White | | | | |
| led within 72 hou tygiene. her than "natura" nt, the Wedge | 15. Decedent's Ed (Specify only highest gra | ducation | 16a. Dece | edent's Usual Occu | pation | kina | 16b. Kind of Bus | siness/Industry | | | | |
| ithin no | Eiamentary/Secondary (0-12) | College (1-4or 5+) | | | during most of wor ad) | A TO | | | | | | |
| od w | 6 | | Homen | naker | | Own Home | | | | | | |
| d oth | 17. Fathar's Name (First, Middle, Last, | | | | | | ame (First, Middle, Maiden Surnema) ta Cosentini | | | | | |
| Men | Romeo Bionconi | | | | | | | | | | | |
| and 2 sh selth end 127 le m er traum | 19a. Informant's Name/Reletionship (Richard Fox/Son | | | | Rural Route Number, City or Town, Stete, Zip Code) nold, Maryland 21012 | | | | | | | |
| Peges 1 tent of He nt: If Item iry or oth | 20a. Method of Disposition 1 | | | | | | | | | | | |
| mit. | 21. Signature of Furniyal Servica Licar | 1500 | 2 | 22. Name and Addr | ess of Facility | John C. M | Hiller I | nc | | | | |
| SOFEE | 1010 | John C. Miller Inc. | | | | | | | | | | |
| | 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between | | | | | | | | | | | |
| Physician | ahock, or heart failure. List only particause on each line. | | | | | | | | | | | |
| /Medical | Immediate Cause (Final disease or condition rasulting in death) a. Care Aro Util Ouler acceptant Due to (or as a prosequence of): | | | | | | | | | | | |
| Examiner | | | | | | | | | | | | |
| <u> </u> | Dua to (or as a consequence of): b. Due to (or es a consequence of): | | | | | | | | | | | |
| rificate be executed ng physician and as the burial-transit | | | | | | | | | | | | |
| an an an inal-trinial-tr | Sequentially list conditions, If eny, leeding to immediate cause. Enter Undartying Cause (Disaase or Injury c. | | | | | | | | | | | |
| ta be | that initiated events | c. Due to | | | | | | | | | | |
| Med h | resulting in deeth) Lest | | | | | | | | | | | |
| | | d | | | | | | | | | | |
| deeth ce e attendi ed for use siclan/ | Part II. Other significant conditions of | potributing to death but not o | 23b. Did to | 23b. Did tobacco use contributs to the cause of death? | | | | | | | | |
| | 011 | or and a second | | 3 Probably 4 ® Unknow | | | | | | | | |
| igned to be det | Drokely | | | | 1 Yes 2 No 3 Probably 4 ☑ | | | | | | | |
| been should | | | 24a. Was a perform | | 24b. Were autopsy findings available prior to completion of cause of death? | | | | | | | |
| The lar ate has page 2 | | | | | | 4 D V | as 2 DINO | | | | | |
| or. p | 25. Was casa referred to medical | | | | | | | | | | | |
| Physician; r this certific ral director, TO Be | axaminer? | Hospitel: 1 ☐ Inpatient 2 | ith (Check only or | | - (Cit-) | | | | | | | |
| Physic rithis coral direction 1: To | 27. Mannar of Death | 28a. Data of Injury (Month, Day Year) | lome 5 Reside | | | | | | | | | |
| ding the truck | 1 Matural 5 Pending | | 28b. Time of Injury | Wo | rk? Yes 2 No | | | | | | | |
| Attending is death. octor: After by the fune liftcation | 3 Suicide 6 Could not be | Suicide 6 Could not be | | | | | | 281. Location (Street and Number or Rurel Route Number, | | | | |
| tal or Attending P rs after death. al Director: After t led in by the funer: Certification: | 4 Homicide determined | building, atc. (Spe | cify) | , | | City or Town | | | | | | |
| To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2 Medical Certification: To Be Comp | 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam | yalclan: To the best of my kiner: On the basis of exami | nowledge, deal | th occurred at the to | ime, date and place opinion, death occu | , and due to the c rred at the time, d | ause(s) and mar ate and place, e | nner es stated. nd dua to tha cause(s) | | | | |
| Mec Mec | 29b. Signature and title of cooper | 2 | 29d. Data signed (Month, Dey, Year) | | | | | | | | | |
| F 2 F 8 | 1000 | 4. A A | | 1 | se number | - | Lila lac | | | | | |
| | 12 1/h | 8428 | | 7/20/ | 14 | | | | | | | |
| | 30. Neme and address of person who | completed causa of death (It | em 23a) (Type | , Print) | 7 1 | 1 | . (| 1 4 | | | | |
| | Datiet du | ogh fillm | 1413 | /tnna/ | 1 he Ro | ay #1 | 06 od | lenton MD 211 | | | | |
| State | 31. Deta filed (Month, Dey, Year) (APR 2-3 1999) | 32. Registrar's Sig | nature | p / | _ | | | | | | | |
| Registrar | APR 2-3 1999 | Banas | B. | BOOK S | / | | | | | | | |



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Bea No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death April I 22, Dr. Romulo Valencia Goco.Sr. 4:00 AM 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 411 Donegal Drive Baltimore Co. Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20, 1924 5. Social Security Number 9. Birthplace (Stete or Foreign 7. Age (In yrs. lest birthdey) Months Days Hours Min Philippines 10XM 20 F Yrs 75 215-42-1707 Usual Residenca of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286-7925 411 Donegal Drive United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 X No Specify: Specify: Filipino 3 XWidowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com completed Surgeon/ Elementery/Secondary (0-12) College (1-4or 5+) South Balto.Gen. Hospital Surgeon 12 08 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Estrella Valencia Lorenzo Lorenzo Goco 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. David L. Goco (Son) 411 Donegal Drive Towson, Maryland 21286-7925 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State Moreland Memorial Park 4/24/1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Servica Licenses Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 rain Part 1. Enter the disease, or complication in a caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert failure. List only one caused an each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequenca of): 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation

physician end the buriel-transit thet the death certificate be axecuted Division of Vital Records, P.O. Box 68760, 88 for use signed by the a The law requires cartificate has t director, this funeral After

Physician

/Medical Examiner

Examiner Physician/Medical þ Completed or Attending Physician: Be To Certification: eftar deeth Director: n 24 hours efter dee ne Funeral Director niately filled in by th

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-1 show any injury or other treumstic event, the National Examines.

Baltimore, Maryland 21215-0020

State Registrar

Medicai

TE Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) and manner stated. 29b. Signatura and title of cartifier

29c. License number 2810 29d. Dete signed (Month, Day, Year) 22,1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569 North Charles Street Suite 205 Towson, Maryland 21204

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Robert C. Shepard, M.D. 31. Dete filed (Month, Day, Year)

6 Could not be

3 Suicide

29a. Certifier

4 Homicide

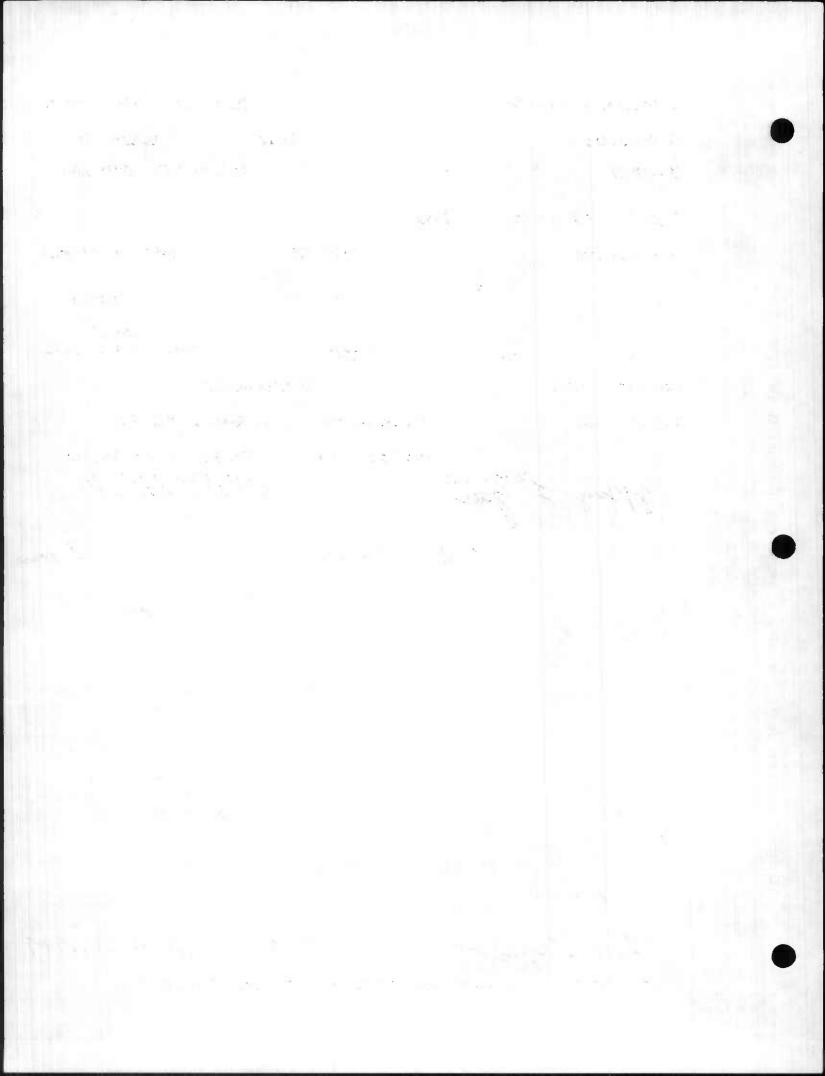
(Check only one)

32. Registrar's Signature

souks

Hospital

To the Hosp within 24 ho To the Fune completely fi



Physician /Medical Examiner pue Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

"natural"

permit. Peges 1 and 2 should be filed within 72 h Department of Heelih and Mental thyliene. Important: if item 27 is marked other than "nat. any inlury or other traumatic event, ins Medicina

the Meryland

death with

hours after

Saltimore, Maryland 21215-0020

Physician/Medicai by Completed Be 2 Certification:

29e. Certifier

31. Dete filed (Month, Day, Yeer)

the burial-transit 88 jo in by the funeral edical

that the death certificate be exec ettending physician as been signed by the c 2 should be detached The lew requires certificate has After this Attending death. To the Hospital or Attendition within 24 hours efter death.

To the Funeral Director: A completely filled in by the fo

Division of Vital

State Registrar

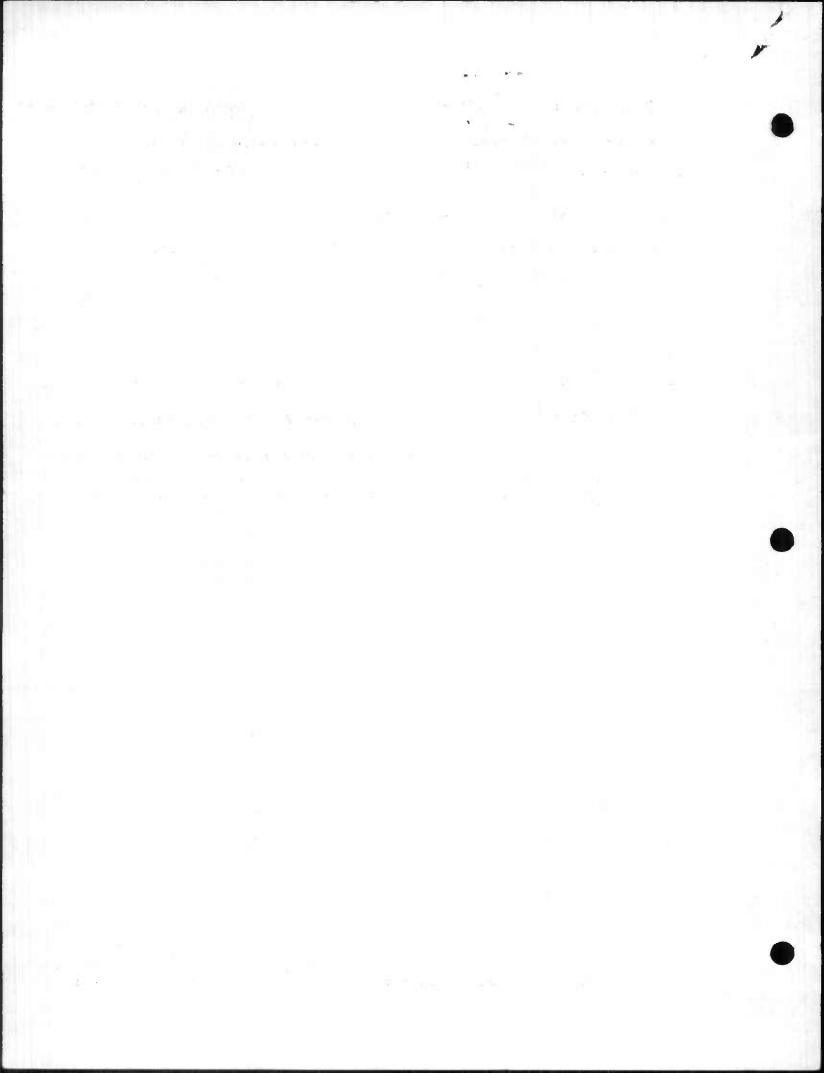
Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 4940 Eastern Avenue Baltimore, MD.

BAP

APR 23

Johns Hopkins-Bayview Medical Center 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedant's Name /First Middle Last 2. Data of Death Month **Physician** Florence Elizabeth Gross 02:39 APPIL 1999 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner BACT+MORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) n/a SINAL OF BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2□x5x 219-20-7316 78 Yrs. Director Md. Aug. 1, 1920 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marytan r than "natural", or items 23s or 28s-f show the Medical Examiner, must be notified at n/a Md. Baltimore toras 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2501 Violet Avenue USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Mantai Status 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: Specify: Black Maryland 21215-0020 by 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16h Kind of Rusiness/Industry Elamentary/Secondary (0-12) Cottege (1-4or 5+) Dietician Hutzler 12th Grade If Health and Mental Hygin Nem 27 is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) 1 and 2 should be Adell Meade St. Elmore McGee, 19a. Informant's Name/Relationship (Type, Print) nephew 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stefa, Zip Code) 1569 Metropolitan Ave. Apt. 8D Bronx, NY 10462 Larry Jordan altimore, 20b. Place of Disposition (Nema of cemetary, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages lent of 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 24 Baltimore, Md. Druid Ridge Cemetery 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Stryice Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 alera 23a. Part Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only ona cause on each line. Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medicai HOURS TAMPONADE CARDIAC Examiner Due to (or as a consequence of) Physician/Medical Examiner Hours MYOCARDIAL INFARCTION certificata be axecuted Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted evants resulting In daath) Last ettending physician and for use as the bunial-tran Due to (or as a consequence of) DAYS Box 68760, ACUTE PAN CREATITIS Dua to (or as a consequence of) 23b. Did tobacco usa contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. P.O. the 2 No 6 1 Yes 3 Probably 4 Unknown ANEMIA Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of daath? The law certificate hes 1 Yes 2 No 2 No Physicien: Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 28d. Describe how Injury occurred 27. Manner of Death 28c. Injury at Work? Certification: or Attending 1 Naturat 5 Panding Investigation daath. 1 TYes 2 □ No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be datarmined 3 ☐ Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida after within 24 hours a edical 29a. Certifier 1 Certifying Physician: To tha best of my knowladga, daath occurred at the time, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

JORGANCE

State Registrar

JOHN MD 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

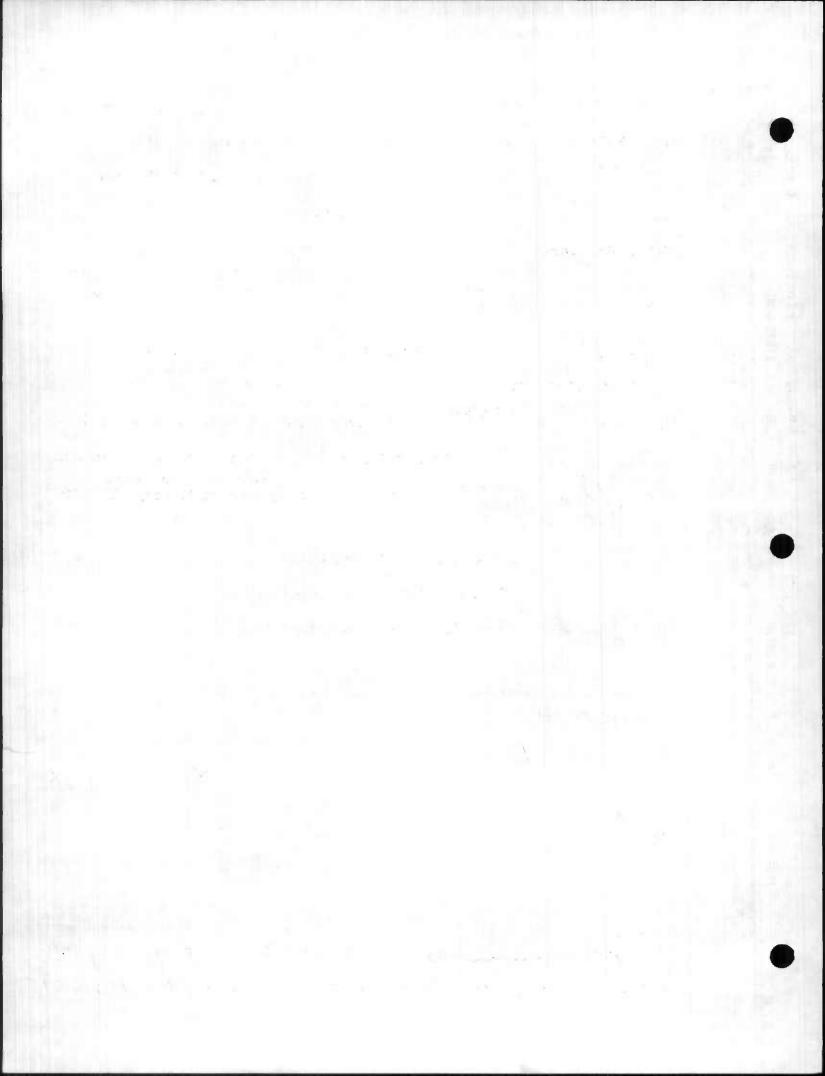
29b. Signaturn and title of certifier

HOSPITAL OF BALTIMORE. SINAI

MM

29c. License number

29d. Date signed (Month, Dev. Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

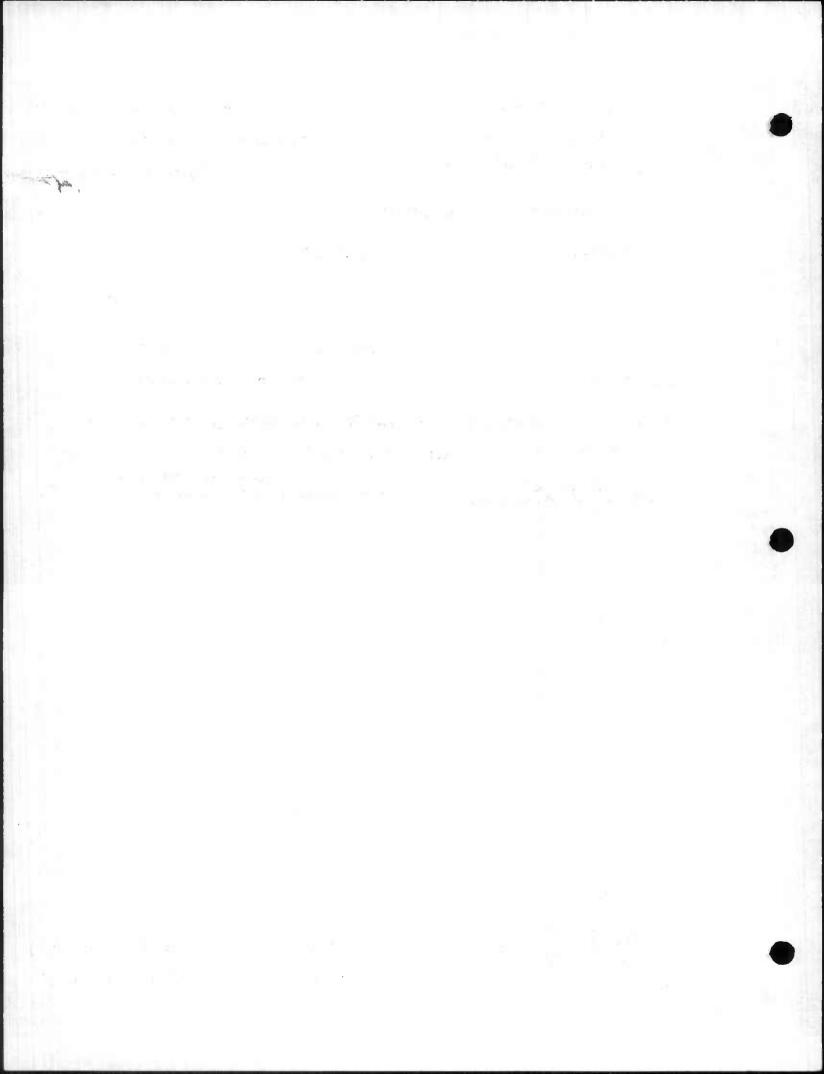
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year KATE GOODMAN 04 20 99 3:00 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Joseph's Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 M Months 239-56-6657 88 Yrs. Oct. 4, 1910 North Carolina Director Usual Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if Itsm 27 is marked other than "natural" ---- any injury or other traumatic average. 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☒ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 122 Oak Drive 21228-5136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Elementary School Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Margaret Estella Ingram John Britt 19a. informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judith Marshall (Daughter) 122 Oak Drive, Catonsville, Maryland 21228 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State e for Disposition (realize C.)
efery, cremetory or other place)
o. Washington Crem. 1 ☐ Buriai 2 ☑ Cremetion 3 ☐ Removal from Stete 4/21/99 Balto. Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert tailure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Infontin /Medical Immediete Cause (Final Myowalen disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner attending physicien end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 36 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Mospital or Attending Physician: The law 124 hours aftar deeth.
 Funers! Director: After this certificate has 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: SNursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No To the Hospital or Attanding Physic within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral directors. 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Statural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D34951 completed cause of death (Item 23a) (Type, Print) El Sudo Cotnorle. 31. Date tiled (Month, Dey, Year) 32 Registrar's Signeture State 2 1999 3

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (sholson Virginia 6:20 AM April 9 1999 4a Facility Name (If not institution, give street end number) A Facility Name (If not institution, give street end number) HOSPITE 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A 7. Age (In yrs. lest birthday) If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) 5. Social Security Number Days 1□M 2√2 F 220 01 4456 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MD BALTIMORE MIDDLE RIVER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 38 G COOL BREEZE DRIVE 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) Race - American indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) WAITRESS FOOD HANDLING 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) HARRY C. WOLF MARIE G. BERNHARDT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD 21237 Data 20c. Localion - City or Town, Stata DOROTHY M. ROSE / SISTER 1302 ROSEWICK AVE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAWN CEMETERY 4/22/99 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE BALTO, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediata Causa (Final diseasa or condition rasulting in death) Due to (or as a consequence of): Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Hypertension 1 | Yee 2 | No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yes 20 No 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Watural

Examiner The lew requires that the death certificate be axecuted buriei-transit and ettanding physician for use as the burie Box 68760 Physician/Medical ed by the datached o signed by t should Completed peen s hes After this cartificata To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, Be 2 Certification:

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Medical

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Manical Examinar must be not find at

permit. Pagas 1 end 2 sh Depertment of Health and Important: if Item 27 is m any injury or other traum page.

Physician /Medical

Examiner

2 should be filed within 72 hours efter deeth and Mental Hygiene.

the Marylend

25. Was cese referred to medical examiner?

2 Accident

3 Suicida

(Check only one)

29a. Cartifiar

4 Homicide

5 Pending investigation

6 Could not be datarmined

28a. Data of Injury (Month, Dey Year)

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as staled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar

MD

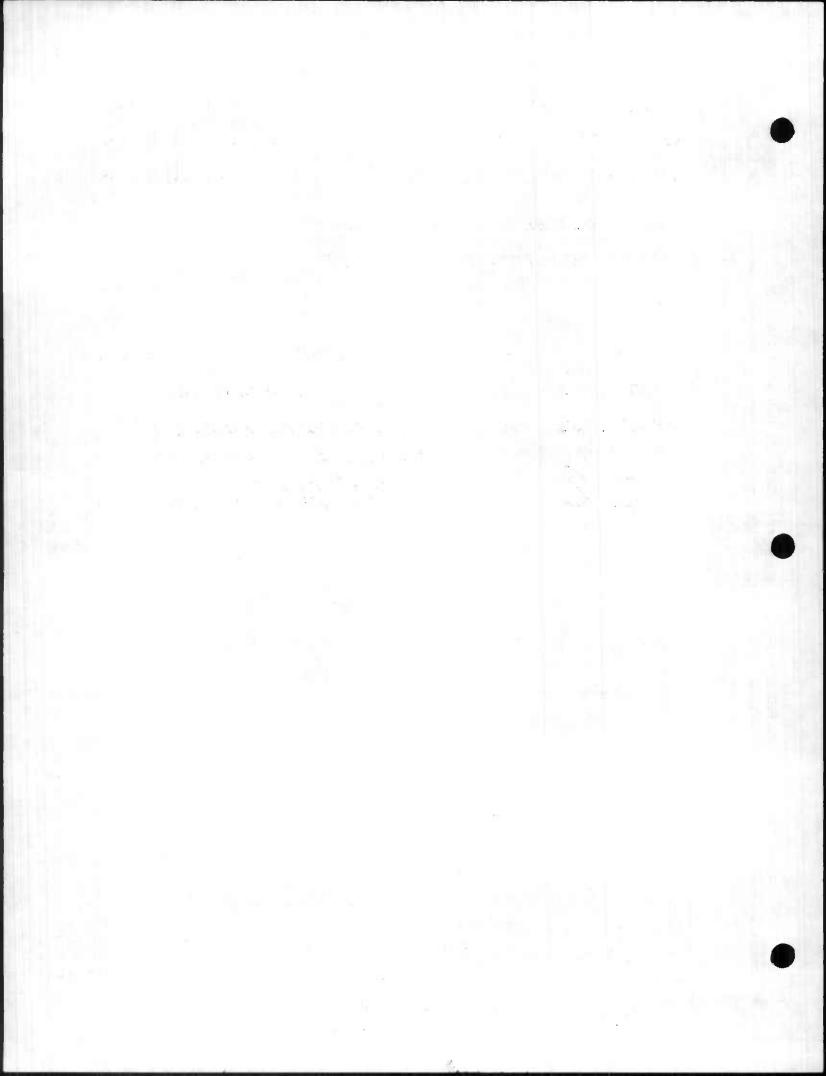
29c. Licanse number P12558 29d. Data signad (Month, Dey, Year) April 19,1999

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)
Maral Donabedian 5601 Loch Rowen Boulevard, Baltimure, MD 21239 Donabedian

State Registrar 31. Date filed (Month, Dey, Year) APR 2 3 1999

32. Registrar's Signature

DOCK !



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth 1999 LILLIAN 5. GEDDES 1215 AM 4b. City, Town, or Location of Deeth 20 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Md BALTIMORE Towson MANOR CARE OF RUXTON If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1 M 2 BF Deys Yrs. 107 218-40-0561 MAR 18 1892 ME Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No BALTIMORE NA Md 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21212 USA 503 AUE OVERBROOK 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 KNo Specify: Specify: WHITE 3 MWidowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOME NA HOME MAKER 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) AMELIA FRANK SCHULER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 503 OVERBROOK AVE, BALTO ROYMOND GEDDES, JR 21212 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 12 Buriel 2 Cremetion 3 Removel from State 199 4 ☐ Donetion 5 ☐ Other (Specify) BALTO LOUDON PARK CEM. 22. Name end Address of Fecility ER FUNERAL HOME, CITTD -21. Signeture of Funeral Service License 23e. Perf. Enter the disease, or compositions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only die ceuse on each line. Rd. BALTE Approximate Intervel Between Onset and Deeth Immediate Ceuse (Finel A theosclevsis disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

ir than "natural", or items 23a or

pemit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Haalth and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or items 23a and injury or other traumatic event, the Mod cal Examinet must and page.

altimore, Maryland 21215-0020

Box 68760.

Division of Vital Records,

with the Maryland r 28a-f show

> physician and the burial-transit USB as I for page 2

director,

Examiner

Physician/Medical by Completed Be To Certification:

that the death certificate be executed signed t peen has certificate this funerai After Attending after death. 3 6 Hospital 24 hours To the Hosp within 24 hou To the Fune completely fi

> State Registrar

edicai

31. Dete filed (Month, Day, Year)

25. Wes cese referred to medicel examiner?

29b. Signeture end title of certifier

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5 Pending Investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Deeth

1 Neturel

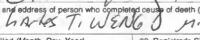
2 Accident

3 Suicide

29a. Certifie

4 Homicide

(Check only one)



28e. Dete of Injury (Month, Day Yeer)

Mil) of deeth (ttem 23e) (Type, Print) M.D

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

0760 CARC

29c. License number

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) 99

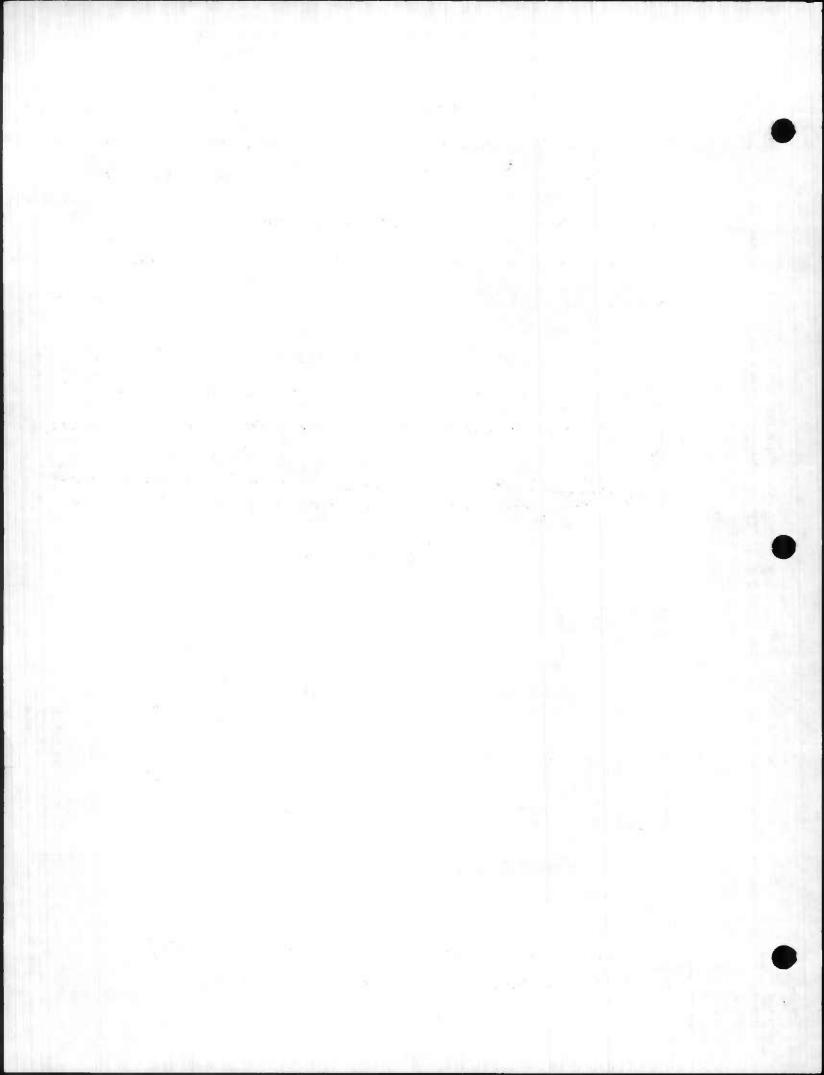
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

32. Registrer's Signeture



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Yeer **Physician** MILTON R. HONEST APRIL 1999 7:15 AM 20 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE FORT HOWARD VA MHCS FORT HOWARD If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth 7 (Month, Day, 7-16-24 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 10 M 20 F Deys Hours 74 Yrs. MD. 218 18 4682 Director Usual Residence of Decedent the Marylend r 28a-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 No MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with t ä "natural", or items 23a or solical Examiner must be 2933 ALLENDALE RD. APT. B 21216 USA death \ Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊉Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. d 2 should be filed within 72 hours efter th end Mentel Hygiene.
7 Is marked other than "natural", or ite traumatic event, the Medical Exercise. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK þ Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b, Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) PLUMBING EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be CHARLES HONEST UNKNOWN 2 19a. Informant's Nema/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 1359 WALKER AVE. BALTIMORE, MARYLAND 21239 TOYA LEE (DAUGHTER) Health other Ram 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Pages 1 Important: If Its any injury or o 1 Burial 2 Cremetion 3 Removel from State GARRISON FOREST VETERANS 4-26-99 OWINGS MILLS, MD. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one causa on each lina. Approximete Intervel Between Onset end Daath **Physician** Immediata Causa (Final diseesa or condition resulting in deeth) /Medical MYCOSIS FUNGOIDES 2 YEARS **Examiner** Dua to (or as e consaguance of): Examiner The law requires that the death certificete be executed physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Diseasa or injury Due to (or es e consequence of): Physician/Medical thet Initieted events resulting In deeth) Lest Due to (or es e consequence of): for use as t signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA Records, þ 24b. Wera autopsy findings avellable prior to completion of cause of deeth? should l 24e. Wes en autopsy Completed certificate hes b lirector, pege 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Physician: 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only ona) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Magnar of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Attending 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigetion 2 Accident ector: by the 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 24 hours after de Funeral Direct 4 - Homicida 8 1 Cartifying Physician: To the best of my knowledga, daeth occurred et the time, date end plece, and due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steled. 29a. Certifier within 24 hor To the Fune completely fi edicai (Check only 29b. Signature end title of certifier License number 29d. Date signed (Month, Dey, Year) APRIL 20, 1999 30. Name end eddrass of person who completed cause of death (Item 23e) (Type, Print) 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052 AURORA C TAN MD, 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar DHMH 16 Rev 6/95

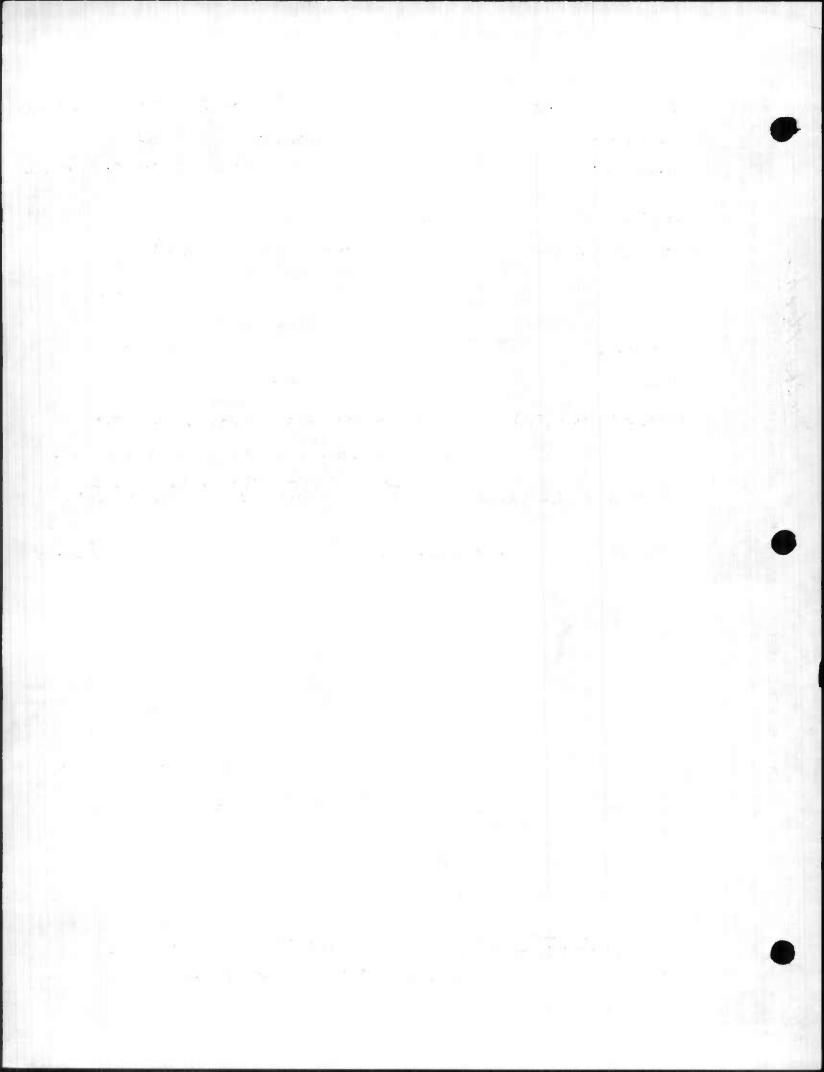
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** April 22, 1999 5:00 a.m. MELBA VIRGINIA HOOK /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 232 Skyline Drive Conowingo If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 1901 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 2ØF Pennsulvania 218-46-0544 98 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yea 2 X No Maryland Cecil Conowingo must be notified Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 232 Skyline Drive 21918 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-tt Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Naver Married 2 ☐ Married 1□ Yea 210 No altimore, Maryland 21215-0020 Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Henry Aro Anne Zamanacek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health ? Item 27 is 21918 William H. Hook (Son) 232 Skyline Drive. Conowingo, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8 1 Burlal 2 □ Cramation 3 □ Removal from Stata 4/24/99 Glen Burnie, MD. Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 21. Signature of Funeral Service Licensee lleus ucan Ce 610 W. MacPhail Road. Bel Air, MD. 21014 23a. Part1. Enter the disaasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final CA AMNOCAS

Dee to (or as a consequence ot): disease or condition resulting in death) Examiner Examiner physicien and s the buriel-trans Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificete be execut Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence ot): ettending pl signed by the a d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy tindings available prior to complation of causa of death? Completed 24a. Was an autopsy page 2 s 2000 1 Yes 1 ☐ Yes certificate or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending 1 ∏ Yes 2 □ No death. invastigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, larm, street, tactory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of certifier 020673 4/27/9/ 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Belain 7672 NU Gernge Lowe 31. Data tiled (Month, Day, Year) 32. Registrar's Signature State

Registrar **DHMH 16 Ray 6/95**

APR 23 1000



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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|---|--------------------------|----------------|-------|
| State of Maryland / | Department of Health and | Mental Hygiene | 13355 |
| G771 5-3-99 WR. | Certificate of Death | Reg. No. | 10000 |

| TEMS: #23 | | ART I, 27, | | R MEO G771 | of Marylar 5-3-99 WI | | rtificate o | | | 2. Date of D | Reg. No. | 9 | 3 3 5 5 |
|---|--|---|--|---------------------|----------------------------------|----------------------------------|--|--|---------------|--|--|--------|--|
| Physiciar /Medica | n | Dana Duane Howard | | | | | | | Month APRI | Day | Year 1999 | 2314 | |
| Examiner Funeral Director | | 4a Facility Nama (If not institution, give street and number) BAYVIEW HOSPITAL | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | | ith 4c. Cou | | |
| | | 5. Social Security 214-50 | Number | 6. Sex HOMM 2□ F | 7. Age (In yrs. 49 | | Months De | ear If Ur | der 24 Hrs. | 8. Date of B (Month, D | 9. Birth (9. Bir | | Birthplace (State or Foreign Country) MD |
| death with the Maryland ms 23s or 28s-f show Linuxt be notified at neral Director | - 1- | Usual Residence | | | | | | | | | | | |
| 28a-f ahow notified at | | MD | 10b. County | IA | | City. Town or Localion saltimore | | | | | 10d. Inside City Limits | | |
| 2 6 | 5 | | 0e. Street and Number 2434 Linden Avenue | | | | 10f. Zip Code 10g. Citizen of What 21217 USA | | | | | untry? | |
| | by runeral | 11. Marital Status 1 Never Mer 3 Widowed | ried % Marri | Armed F | 2 ☑ No | I,S. 13. | If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | lace - American Indian, Black, White, etc. City: Black | | |
| nt, the Medical Ex | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High Sch. Grad NA 17. Father's Name (First, Middle, Last) | | | (1-4or 5+) | (Give | cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) COCK Clerk Company | | | ndustry | | | |
| de ava | To Be | Daniel C. Howard | | | | | | 18. Mother's Neme (First, Middle, Maiden Surname) Audrey Frazier | | | | | |
| or traum | | 19e. Informent's Name/Relationship (Type, Print) Zara B. Howard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2434 Linden Avenue Baltimore, Maryland | | | | | | | | ryland | | | |
| important: If fam 27 is marked other than any injury or other traumatic avant, the Monce. | | 20a. Method of Disposition XXBurial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetory or other place) Kings Mem. PK. Cem 04-24-99 Randallstown, MD | | | | | | | | | | | |
| any inju | | 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Baltimore, Maryland 2 WM.C.March FH 1101 E. North Avenue | | | | | | | | | | | |
| /sician | shock, or heart leiture. List only one cause on each line. | | | | | | | | | Approximate Intervel Between Onset and Death | | | |
| miner | | disease or conditi resulting in death) | e or condition BLUN I FURUE INJURIES OF HEAL | | | | | WITH COMPLICATIONS | | | | | |
| in the | ner. | | | | | | | | | | | 1 | |
| ficate be executed physician and is the burial-transit edical Examiner | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | Due to (d | or es e conse | quence of): | | | | | | |
| physic s that b | 2 | that initiated event resulting in death) | S | 6 | Due to (or as a consequence of): | | | | | | | | |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical

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Completed

8

Certification: To

edical

-

cata has been signed by the attending page 2 should be detached for use as

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes

25. Was casa referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? P 1 Natural 5 Pending 1 Yes 2 No

SUBJECT STRUCK investigation 2 Accident APRIL 4, 1999 3:20 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 500 PRESSTMAN STREET 28e. Place of Injury - At home, lerm, street, lactory, office building, etc. (Specify)

4 🔀 Homicide STREET

BALTIMORE, MD.

APRIL 17,1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licensa number

O.C.M.E

rus leted cause of death (frem 23a) (Type, Print) 30. Name and address of person who comp

111 Penn Street, Baltimore, Maryland 21201

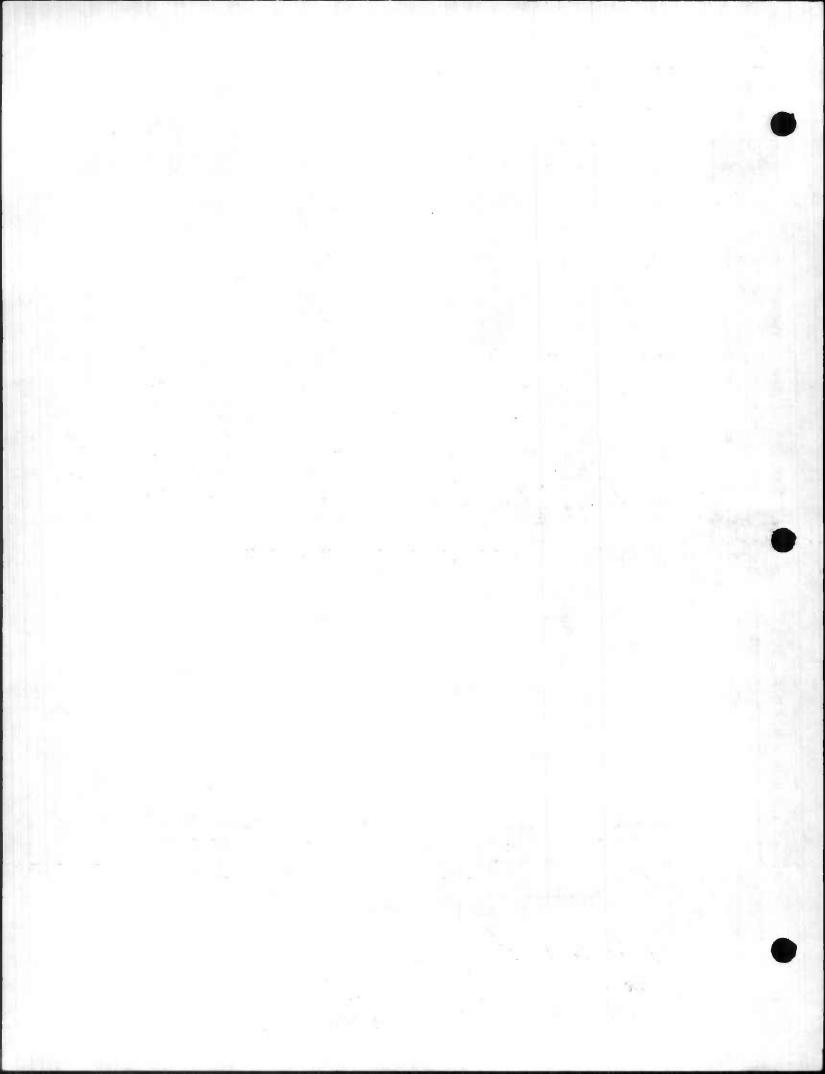
State Registrar

THEODORE 31. Date filed (Month, Day, Year) APR 2 3 1

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,



State Registrar

Medical

31. Data filed (Month, Day, Year)

29b. Signature and fittle of certifier

29a. Certifier (Check only one)

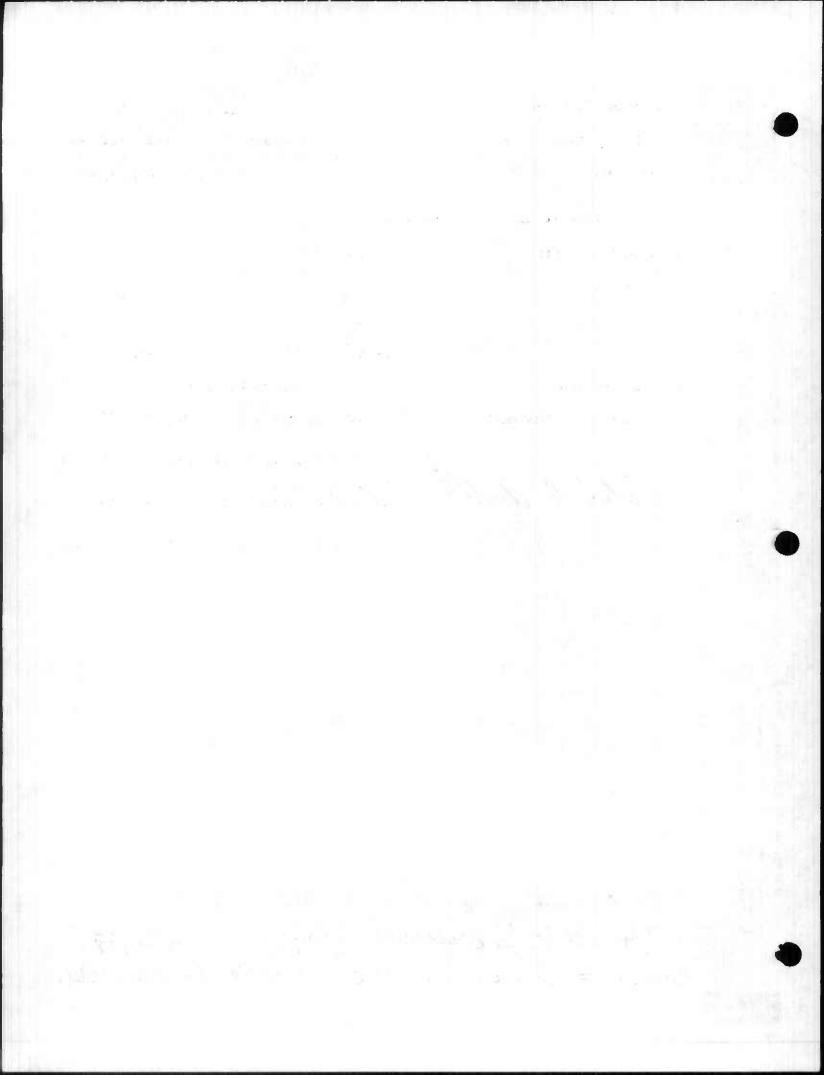
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Straut E. Sclouich, U.V. 900 Bestgate Rd. Annapolis, Und. APR 23 1999

32. Regisfrar's Signatura

152 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted.

29d. Data signed (Mopth, Dey, Year) 4/20/99



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month Erika Hose 40 4b. City, Town, or Location of Death 4a Escility Neme (If not institution, give street and number) 4c. County of Deeth Gen Burnie Glen Burnie If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 93 Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 10 M 20 F Months Days Hours 30 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits (3 AA Burnie 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 Branch urnace USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Whitp 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

lomema

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Cemeter

201 Longwood Aug

Physician /Medical

Physician

/Medical

Examiner

216.

10s State

Director

Funeral

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Completed

Be 0 MO

Elementary/Secondary (0-12)

12 17. Fsther's Neme (First, Middle, Last)

Jeanar Hose

4 ☐ Donetion 5 ☐ Other (Specify)

20a. Methed of Disposition

19e. Informent's Neme/Reletionship (Type, Print)

1 Burial 2 Cremetion 3 Removel from State

Funeral

Director

ò

Nerms 23a

natural', or

permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If hem 27 Is marked other than "n

72 hours after

Baltimore, Maryland 21215-0020

other traumatic event, the Medical Examiner must be notified at

Examiner

attending physician and for use as the buriel-transit A hours after dea... To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th

After t

or Attending

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician/Medical Examiner Completed by Be 10 edical Certification:

21. Signature of Feneral Service Lio 22. Name and Address of Facility
Finic Functured Home Pa ttl. Enter the docume, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart tailure. Ust enty one cause on each line. 426 Crain Sw Glen Burrie Immediate Cause (Final INCARLERATED HZRNIA disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lsst Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown CONGESTIVE 24a. Was en eutopsy performed? THYROMIS

CANDIAC ISCHEMIA 25. Was case reterred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 A Natural

2 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of

College (1-4or 5+)

GPSSIM

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

18. Mother's Name (First, Middle, Maiden Surname)

Date

Apr 26 99

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Buttne

md 21061

Md 21061

24b. Were sutopsy findings svailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

7 DAYS

20c. Location - City or Town, State

Baltimore

Glen Burnie

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted.

2 0 No

29b. Signeture end title of continue

31. Dete liled (Month, Day, Year)

29a. Certifier (Check only one)

> 29c. License number DSZ360

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Neme and address of person who gompleted cause of death (Item 23a) (Type, Print)

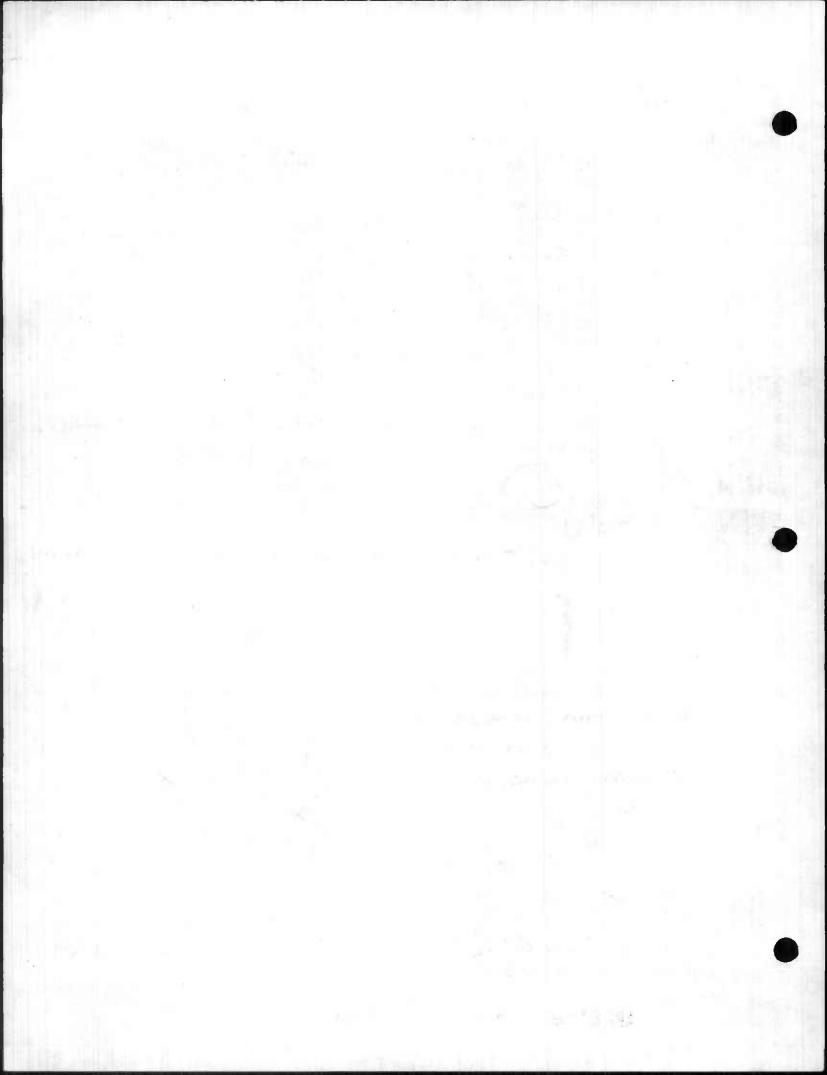
Hospital:

300 Pikesville

State Registrar

APR 23 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 99-2260-510 SHAWN H. State of Maryland / Department of Health and Mental Hygiene. **JOHNSON** ASP Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** shawn APRIL 19 1999 2:25 A /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Cleath Examiner SHOCK TRAUMA MARYLAND BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Days Hours 217-82-2084 Months 1 M 2 F Yrs. Director Usuei Residence of Deceden 10a. Slete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ahow the Medical Examiner must be nothled at 1 X Yes 2 □ No Director Marylana imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 6 Funeral 21 d - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race 11. Meritel Stetus Bleck, White, etc. filed within 72 hours after thygiene. thygiene. 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 □ Widowed 4 □ Divorced HMerican Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: if Item 27 is marked other tha any injury or other traumatic avant, that page. ato 0 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harlan Johnson Elaine (
199. Informent's Name/Reletionship Type, Print) (grandmother Jeb. Meiling Address (Street and Number of Rural Route Number. 4301 Ma 20b. Place of Disposition (Name of Maine earson /Date 20a. Method of Disposition 20c. Location - City or Town, Stete ery, crematory or other place) 1 Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility ome Joseph Ave W. North Ito. Enler the disease, or compileations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or hearfullure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medicai the Due to (or es e consequence of): 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vitai Records, P.O. 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No signed t by 24b. Were eutopsy findings evailable prior to 24a. Wes an autopsy performed? Completed peeu completion of cause of death? nospital or Attending Physician: The Yune 24 hours after death.

The Funeral Director: After this vietely filled in post. 2 No 2 No certificata 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2□ No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient → DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Dete of tnjury Injury Subjec 1 Naturel 5 Pending + she 419199 1 Yes investigetion 2 Accident AM 6 Could not be determined Location (Street and Number City or Town, State) 3 Suicide Number or Aural Route Number, 150 61 - 64 West Squatofo 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) vehide Bultimore 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and member as stated. 29e. Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 19,1999 O.C.M.E. 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEOPILE MIKIN

MA (D)

DHMH 16 Rev 6/95

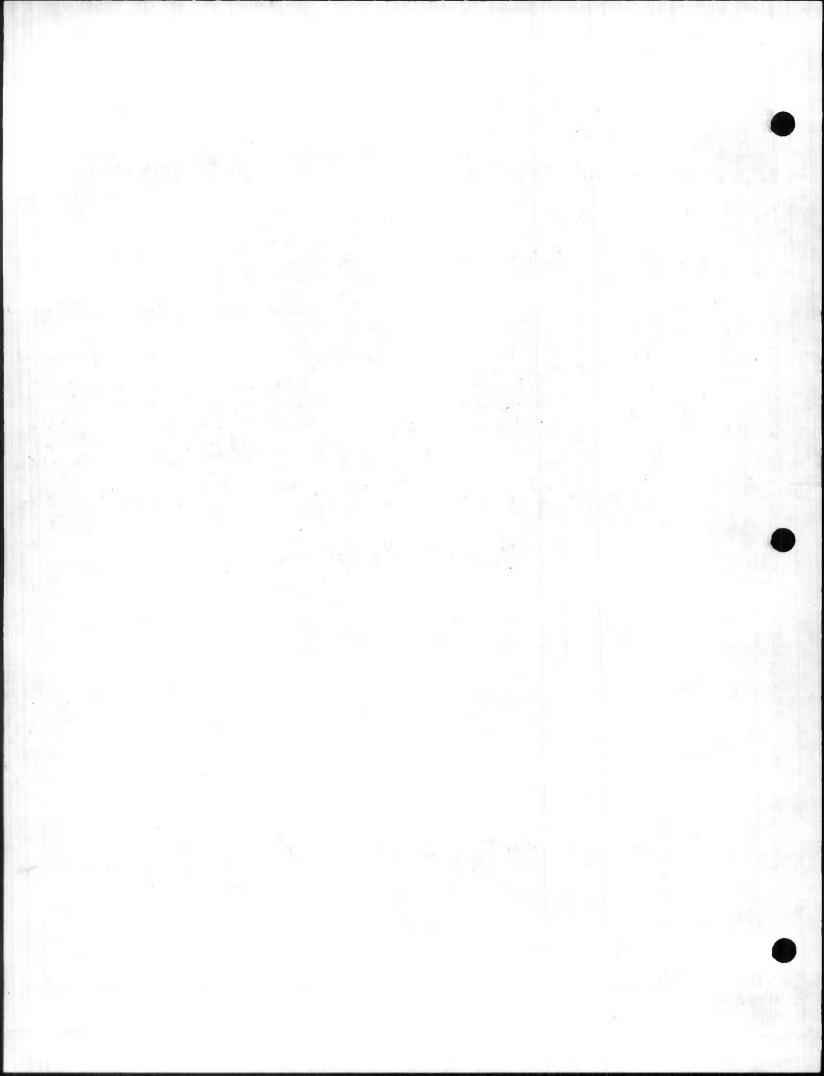
State

Registrar

31. Dete filed (Month, Dey, Year)

1999

32. Registrar's Signeture,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JOOF Fecility Name (If not institution, City, Town, or Location of Death give street end number 4c. County of Death 181 NA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 217-56-5547 1 M 2 F 77 09-01-21 WI Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 729 Argonne Drive 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. 3√ Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) Nurse Church Home Hosp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Thomas Mayne Hannah Balfour 19e. Informant's Name/Reiatlonship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 729 Argonne Drive Baltimore, MD 21218 Humphrey Johnson 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Woodlawn Cemetery 04-26-99 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Neme and Address of Facility Baltimore, Mary 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediata Cause (Finel Accident . Cerebral Vaxalan disease or condition resulting in death) Due to (or as e consequence of) Due to (or as e consequence of): Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown mellitus 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

pue

Department of important: if any injury or once.

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

r than "natural", or items 23s or 28s-f show

i Hygiene.

i. Pages 1 end 2 should be filed wi tment of Health and Mentel Hygien tant: If Itam 27 Is marked other th ijury or other traumatic event, Ita

Funeral Director

Completed by

filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

Examiner the burial-transit ettending physician for use es the buna Physician/Medical been signed by the e Completed by Be Certification: To

or Attending Physician: The law requires that the death certificate be executed

certificate hes

this

After

after death.

within 24 hours a To the Funeral D Hospital

illed in by

P.O. Box 68760,

Division of Vital Records.

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

1 Yes 2 Dio

25. Wes case referred to medical exeminer? 1 Yes

1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

21234

27. Manner of Death 1 ENatural 2 Accidant

5 Pending investigation 6 ☐ Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and pieca, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2314 ...E. RD

31. Date filed (Month, Dey, Year) APR 2 3

32. Registrar's Signature

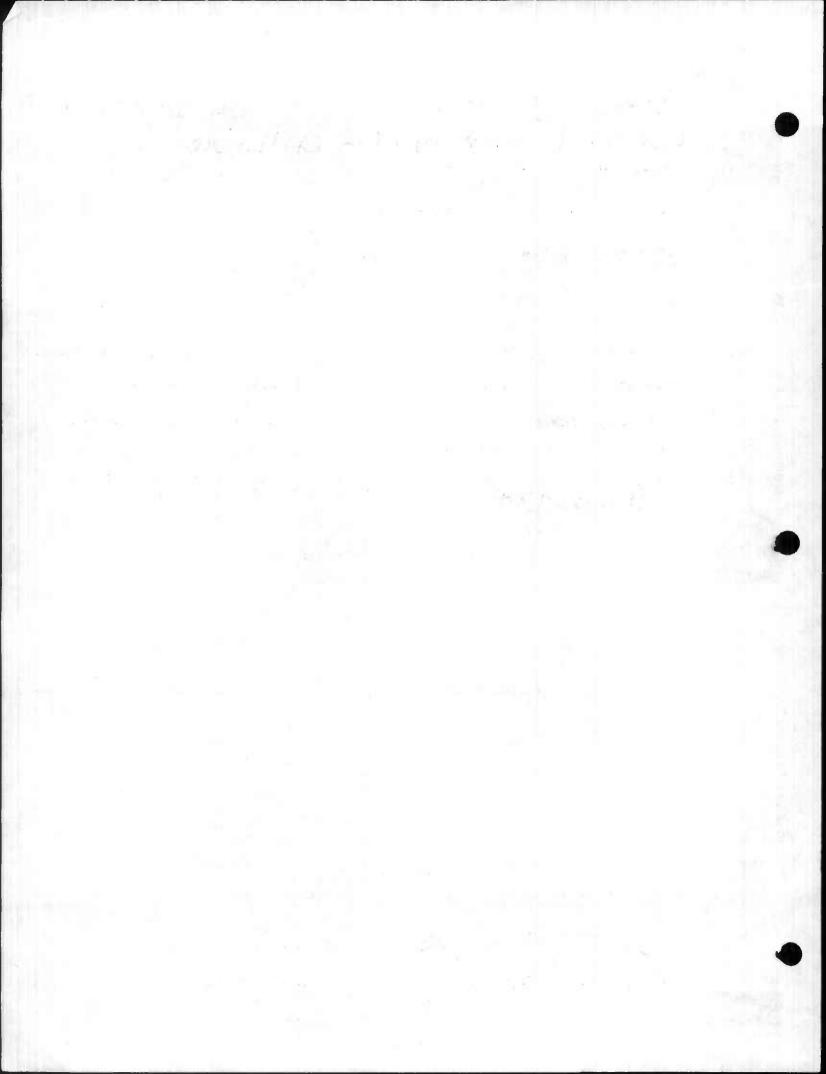
Baltimore

DHMH 16 Rev 6/95

Registrar

State

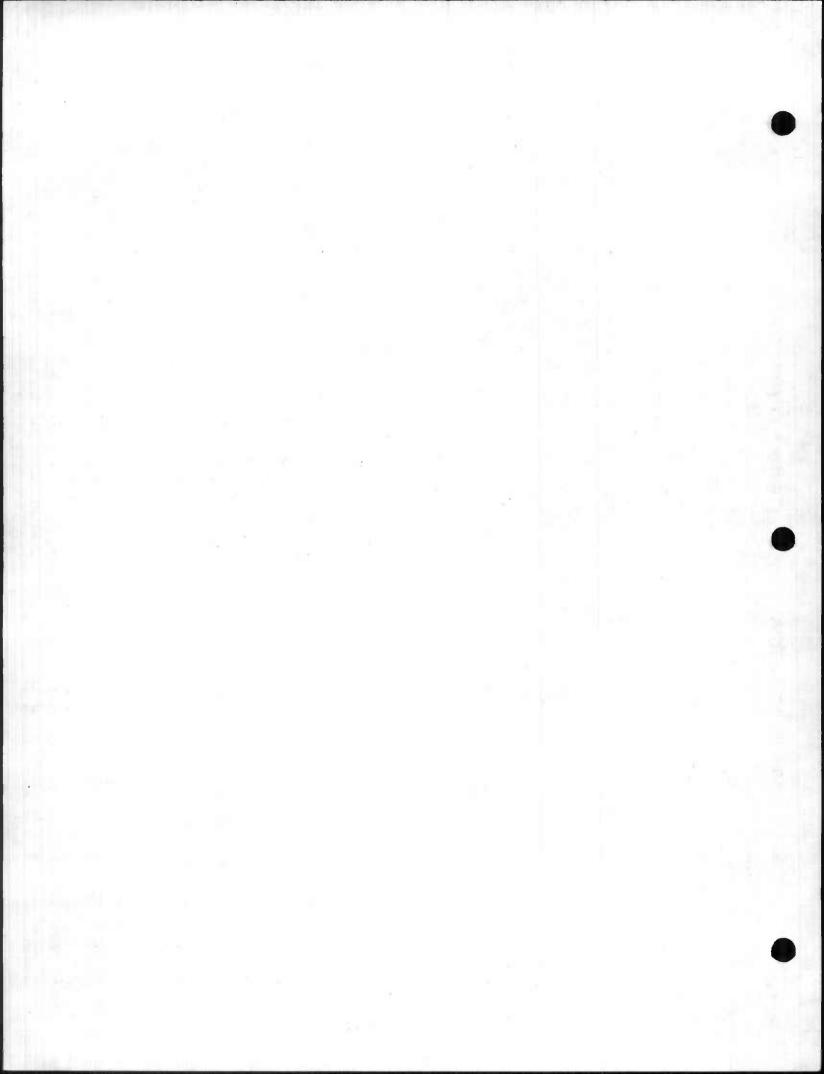
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Liam Jones | | Otate of W | aryland / L | Certificate of | of Death | | leg. No. 9 9 | 13: | 360 | | | |
|--|--|---|--|---|--|---|--|---|----------------------------|--|--|--|
| 61 -1-1- | 1. Decedent's Neme (First, Middle, | Last) | | | | | th Dey | Year 3. T | Time of Death | | | |
| Physiciar /Medica | willam | Jones | , Jr. | | Month April | 15. 199 | | 11:05 AM | | | | |
| Examiner | de Carille, blama Mant Institution | give street and number) |) | | 4b. City, Town, or I | ocation of Death | | | | | | |
| | 11 West 20th S | treet, Apar | tment 6 | C | Baltimo | re | N/ | Δ' | | | | |
| Funeral Director | 5. Social Security Number 219–26–5524 | | ge (In yrs. last bir 50 | thday) If Under 1 Ye Months De | | 8. Date of Birth (Month, Day 07-22 | Year) -38 | | State or Foreign | | | |
| 2 > | Usual Rasidence of Decedent | | 10c. City, Tow | | | | | Land | | | | |
| Maryland 21215-0020 d 2 should be filled within 72 hours after death with the Maryland th and Mantal Hygiene. T le marked other than "natural", or itema 23e or 28e-f show traumatic avent, the Medical Emitting mant to notified at | 10a. Stete 10b. County | A | * | | | | | | side City Limits Yes 2 No | | | |
| | TID IN | A | Balti | | | | | 2169 21110 | | | | |
| | 10e. Street and Number 11 West 20th | Street | | 10/. Zip Code 21218 | | | 10g. Citizen of V USA | | | | | |
| | 3 ☐ Widowed 4 ※ Divorced | Armed Forces? | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin fit Yes, specify Cuban, Mexican, I | | | pecify Yes or No- o Rican, etc.) | | e - American Ind k, White, etc. Black | lian, | | | |
| 1 21215-0 led within 72 ho tygiene. The then "netural, It, The Medical | 15. Decedent's | Education | 16a. Decedent's Usual Occupation (Give kind of work done during most of work | | | kina | 16b. Kind of Bu | siness/Industry | | | | |
| 21 thin 21 | Elementery/Secondary (0-12) | College (1-4or | r 5+) Ille. DO NOT use retired) | | | ning . | Mecha | nic Sh | ion | | | |
| d 21 filed will thygien from the | llth Grade | NA | M | echanic | | | | | ЮР | | | |
| Maryiand 2 42 should be filled in and Mental Hygis fraumatic avent, tr | 17. Father's Nema (First, Middle, La | st) | | | 18. Mother's Nan | na (First, Middle, | Maiden Sumam | me) | | | | |
| yian build be Mental Mental arked c | William | Jones | 5 | | Ida | | У | | | | | |
| Maryid 2 should and Mer Is marks aumatic | 19e. Informant's Name/Reletionship | (Type, Print) | | | eet and Number or Ru | | | | | | | |
| Health Health Health Health | Barbara Bro | wn | | | lnord Ave | enue Ba | ltimor | e,MD. | 21205 | | | |
| 0 -115 | 20a. Method of Disposition **DBurial 2 | Diamond from State | comete | Disposition (Name of y, cremetory or other p | plece) | Date | 20c. Location - | City or Town, Si | late | | | |
| Pages nent of int: If the | 4 Donetion 5 Other (Spe | 04-22-99 Dundalk, MD | | | | | | | | | | |
| Baltim permit. Pag Deperment Important: h any injury o | 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Baltimore, Maryland @1202 | | | | | | | | | | | |
| Depe Depe | Blmad P Jumes WM.C. March FH 1101 E. North Avenue | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Physician | shock, or heart teilure. List of | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tellure. List on your cause on each line. Approximate Interval Between Onset and Death | | | | | | | | | | |
| /Medical | Immediate Cause (Final | | | | | | | | | | | |
| Examiner | disease or condition resulting in deeth) a. Hhervscleratic Concligrascidor Suscesse | | | | | | | | | | | |
| | | | Due to (or as a | consequence of): | | | | i | | | | |
| icate be executed physicien end s the burial-transit | | b | | Museum a | | | | i | | | | |
| y yecu yecu yeu al-tra | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): | | | | | | | | | | | |
| 68760, ifficate be executed g physicien end as the bunal-transit | | | | | | | | | | | | |
| Phys s the | | | | | | | | | | | | |
| Cords, P.O. Box 6: v requires that the death certific been signed by the attending p should be deteched for use as | d. | | | | | | | | | | | |
| The lew requires that the death cert rate has been signed by the attending page 2 should be detached for use a Completed by Dhysician A | | | | | | | | | | | | |
| O & ## 2 | Pert II. Other algnificant conditions | | | | cause of death? | | | | | | | |
| deta deta | | 1 Yes 2 No 3 Probably Unkn | | | | | | | | | | |
| Records, P.O. to leave requires that the de the bas been signed by the tight 2 should be detached by Physical properties. | | 24a. Was an autopsy 24b. Were aut | | | toney findings | | | | | | | |
| requence of the control of the contr | | performed? | | available | topsy findings prior to ion of cause | | | | | | | |
| | | | | | | | partial | | ? | | | |
| The The page | | | | | | 1,000 | as 2 No | Yes | 2□1No | | | |
| Vital | 25. Wes case referred to medical examiner? | 1000000 | | - T | | ith (Check only or | ne) | | | | | |
| | 1 △ Yes 2 □ No | Hospital: 1 Inpetic | | thatient 31 DOV | | ome 5 Resid | ence 6 Oth | er (Specify) | | | | |
| After I | | | | | | | ow injury occurr | red | | | | |
| Attending or death. Ctor: After by the fune liftcation | | | | | | | COL Landing (Chart and Number of Burn) Dark Number | | | | | |
| DIVISION OF To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To | 4 Homicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | | | | | | | | | | | | |
| | 29a. Certifier 1 ☐ Certifying I (Check only one) 2 ☑ Medical Ex | Physician: To the best aminer: On the basis of and manner st | f examination and | | | | | | ause(s) | | | |
| To the composition of the compos | 29b. Signeture end title of certifier | | 29d. Date signed (Month, Day, Year) | | | | | | | | | |
| | 1 Nonnan | 1/1/mils | 60 | | O.C.M.E. | 1 | April 16 | 1999 | | | | |
| | 30. Name end eddress of person wh | o pompleted causa of d | leath (Item 23a) (| Type, Print) | 100 | | | | | | | |
| | Dennis J. | Chuten | , | | n Street, | Baltimor | re, Mary | land 21 | 1201 | | | |
| State | 31. Dete filed (Month, Dey, Year) | | ar's Signature | | | | | | - | | | |
| Registrar | 31. Dete filed (Month, Dey, Year) APR 2 3 1999 | Sender | v 14 | Louis | | | | | | | | |
| | | 1 | - Adam | 000015 | | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 12.15 PM 04 -LEWIS 99 MALLIUM 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death HOSPICE BALTIMORE Tif Under 24 Hrs. NA GILCHRIST If Under 1 Year 8. Date of Birth (Month, Day, Year) 05 - 30 - 52 Birthplace (State or Foreign Country) 5. Sociel Security Number 6 Sex 7. Age (In vrs. lest birthdev) 1MM 2DF Months Days Hours Min 216. 58- 2410 Usual Residence of Decedent Yrs. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No PIKESVILLE MO 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 4526 KOAD 21208 USA 14. Rece - American indien. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ZYes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) 2 YRS Elementary/Secondary (0-12) STATE OF MD TH GRADE ORRECTIONAL IFFICER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) LEWIS . EWELL WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PIKESVILLE, MD. 21208 B. MARIE JAPSCOTI 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) PARK KANDALLSTOWN, MD MEMORIAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GREENE FUNERAL VAUGHN C. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart-fellure. List only one cause on each line. BAUD. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) 6 months Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner, stated. 29a. Certifier

Division of Vital b Hospital To the Hor within 24 h To the Fur completely

Physician

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Examiner

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rel', or items 23a or 28a-f ehov Examiner must be notified at

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7 is marked other than "natur traumatic event, the Medical

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permit. Pages Department of Important: If it eny injury or o

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Certification:

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death v

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.

State Registrar

31. Dete filed (Month, Day, Year)

290. Signature my die of pertifier

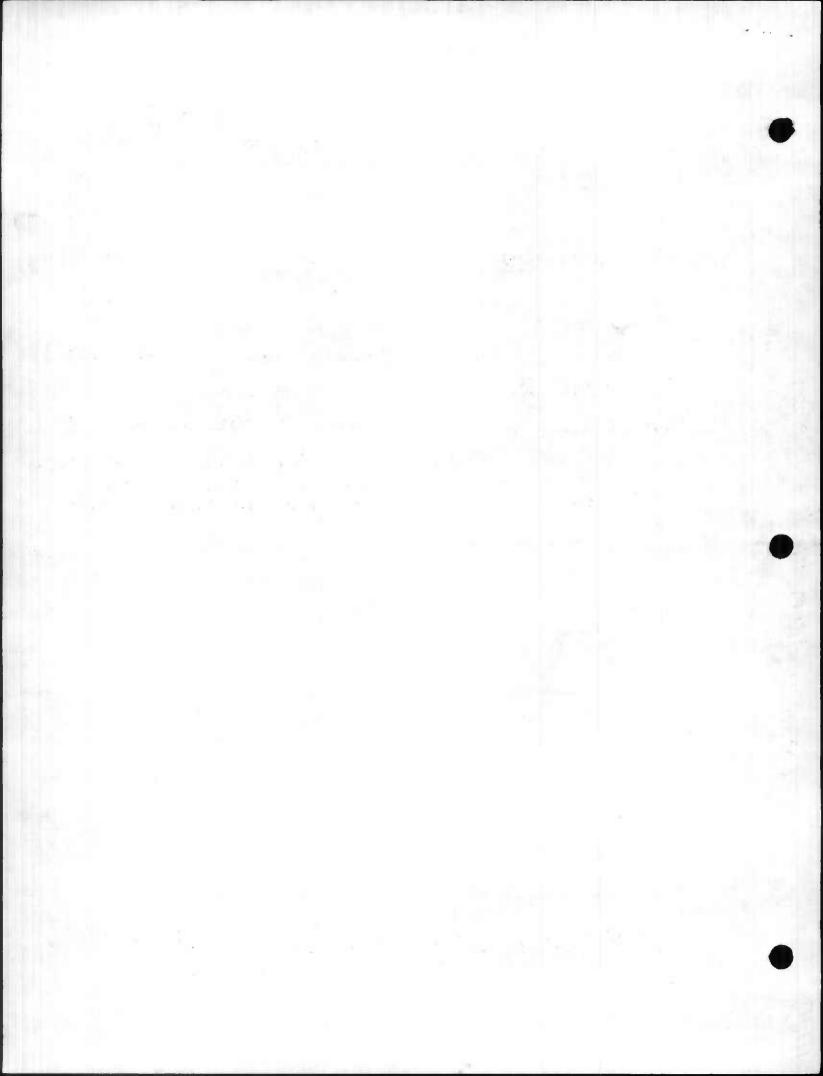
N. Charles St, Balto. ms 6209 32 Registrar's Signature

30. Name and address of person who completed ceuse of death (flem 23a) (Type, Print)

29c. License number

29d, Date signed (Month, Dey, Year)

ril21,1999



| | | | | | State of M | larylar | | | | Health a | nd Me | | jiene 9 leg. No. | 9 1 | 336 | 2 |
|-------------------|---|--------------------|---|---|---|-------------|----------------------------|----------------------|--------------------------------|---------------------------------|-------------------------|---------------------------------------|---------------------|-------------------------------|---|---------------|
| Г | Physici | an | | ame (First, Middle, La | | | | | | | 2 | 2. Date of Dee Month | th Day | Year | 3. Time of | |
| | /Medi | | John | | L | ower | У | | | | | APRIL | 21 | 1999 | 1:45 | A.M. |
| | Examir | er | 4a Facility Name | (If not institution, given | ve street end number |) | | | | 4b. City, Tow | n, or Loca | ation of Death | 4c. Count | y of Death | | |
| | Funeral Director | | 5. Sociel Security 212-22 | 2-0145 | | ge (In yrs. | last birthdey, Yrs. | If Und | der 1 Year s Deys | | 4 Hrs. g | Date of Birth (Month, Dey 07 24 | , Year) | 9. Birthpi Coun S • | | r Foreign |
| | and ** | | Usuel Residence 10e. State | 10b. County | | 10c. C | ty, Town or L | ocation | | | | | | 10 | d. inside Cli | ty Limits |
| | f aho | ò | MD | NA | | | Balti | mor | 0 | | | | | | 1 X Yes | 2 No |
| | the 1 | Director | 10e. Street and N | | | | Daici | 7 | Zip Code | | | 1 | l0g. Citizen of | Whet Coun | irv? | |
| 21215-0020 | 72 hours effer death with the Maryland natural', or ferna 23e or 28e1 ahow disal Examiner must be notined at | by Funeral Di | 11. Marital Status | Parkwoods arried 2 Married | 12. Wes Deceden Armed Forces 1 Yes 2 K If Yes, Give Year or Detes: | Ever in U | J,S. 13. | Wes Dec If Yes, s | 1216 cedent of locality Cub | Hispanic Origi pan, Mexican, | in? (Speci Puerto Ri | Ify Yes or No- ican, etc.) | | ca - America ck, White, of | | |
| 9 | 72 hours | 8 | | 15. Decedent's E | ducation | | 16e. Dece | dent's Us | suel Occu | petion | | | 16b. Kind of I | | | |
| 215 | n n n | Completed | | pecify only highest gracecondary (0-12) | ede completed) College (1-4or | 5.1 | (Give | kind of t DO NOT | work done use retire | during most (ed) | of working | 7 | | | | |
| 21 | yiens. | EO | 6th gra | | na na | 3+/ | Cons | tru | ctic | n Wor | ker | lu lu | Mhite | & Tu | rner | Co. |
| Maryland | Mental Hyginarked other | To Be C | 17. Fether's Nem | ne (First, Middle, Last | | n | O.O.I.E | , G | | | | First, Middle, | | | known | |
| ary | E E | 1- | 19a. Informent's | Neme/Reletionship | (Type, Print) | | 19b. Mall | ng Addre | ss (Stree | t end Number | or Rural | Route Numbe | r, City or Town | , State, Zip | Code) | |
| | nd 2 aith a 27 le | | Thelma | Lowery- | Wife | | 2810 | Pa | rkwo | ood Av | e. | Baltin | nore M | id 2 | 1216 | |
| re, | - I 5 5 | | 20a. Method of D | Disposition | | | Place of Disponentery, cre | osition (A | leme of | | | Date | 20c. Location | | | |
| E | age ant c rt: # | | | 2 ☐ Cremetion 3 ☐ n 5 ☐ Other (Speci | ☐Removel from Stete | | ng Me | | | | 4/ | 26/99 | Randa | llst | own. | Md |
| Baltimore, | - 독특류 | | | Funerel Service Lica | - | 11/2 | 2 | 2. Name | end Addr | ess of Fecility | | 20/00 | ranac | | O W 11 7 | |
| ä | Depa impo any ir | | NX | PRIME. | Thom | 001 | YON | arc | h F/ | H Wes | t ve. | Balt | imore | БМ | 21215 | |
| | _ | | 23a. Part Ente | er the disease, or com | nplications that cause one cause on each | the dea | | | | | | | | 114 | Approximete | 0 |
| | Physician | | shock of h | eert failure. List only | one cause on eech | line. | | | | | | | | 1 | Onset and | veen Deeth |
| <i>)</i> . | /Medical | | Immediete Saus | e (Final | 2110 | 0.0 | Oax | AD | ٨ | | | | | 1 | unb | 40 8 27 44 |
| | Examiner | | diseese or condi resulting in deet | h) | · Qui | Dan! | es a conse | MUDOS C |) | | | | | 13 | whire | noun |
| | | Je. | | | | 7 | 65 a CO1150 | querica | м, | | | | | 1 | | |
| | be axecuted icien and bunal-transit | Examine | Sequentially list if eny, leeding to | conditions, | b | Due to (| or es e conse | quenca d | of): | | | | | 1 | | |
| 260 | | 70 | cause. Enter Un Ceuse (Diseese thet initiated eve | or Injury | C | Due to / | or as a conse | nience o | 4/- | | | | | | | |
| 687 | certificete nding phys use es the | Pa | resulting in deeth | n) Lest | | 200 10 (| JI AS A CONSO | (uerica o | 17. | | | | | 1 | | |
| Box | leath certifice attending ph d for use es ti | 2 | | 6 | d | | | | | | | | _ | | | |
| | death e atten | cia | Pert II Other sto | nificant conditions | contributing to death | but not re | sulting in the | ınderivini | n cause o | iven in Pert I | | 23b. Did to | obacco uae c | ontributa to | the cause o | of death? |
| P.0 | thet tha | by Physician/Medic | | | | | | | | | | | /es 2□ No | | 1/ | Unknown |
| of Vital Records, | been should | Completed b | | | | | | | | | | 24e. Wes o | an autopsy med? | . av | are autopsy f allable prior t apletion of c death? | 0 |
| Re | The law ata has b page 2 s | E C | | | | | | | | | | 1 🗆 Y | es 2 No | | Yes 2 | No |
| ल | ician: Th | | 25. Wes case re | ferred to medical | | | | | | OC Place | of Dooth | | - CTPT | | RIS AT | |
| = | Physician: this certific ral director, | Be c | examiner? | No No | Hospital: | | 1500 | | 01 | hor | | (Check only o | | | | |
| o | Physical distribution | To To | 1 ☐ Yes 2 27. Manner of Oe | | 1 Inpat | | ER/Outpetle | | 28c. inju | 4 LI NUI | | e 5 🗆 Resid | | | // HOSP | TCE |
| o | h. After funer | tion | 1 Neturel | 5 Pending | (Month, D | ey Year) | Injury | М | | ork?]Yes 2∐N | | | | | | |
| Division | To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely lilled in by the funer | Certification: | 2 Accident 3 ☐ Suicide 4 ☐ Homicid | 6 ☐ Could not b | De Bloom of Ir | jury - At h | ome, farm, st | reet, fect | | | | 8f. Location (5 City or Tow | | nber or Rura | l Route Num | nber, |
| - | 2 2 E | Ö | 29a. Certifier | 45 a 44a m | hysician: To the best | of my kn | owledge, deel | h occurre | ed et the t | ime, dete end | pleca, er | nd due to the d | euse(s) end r | nenner es s | eted | |
| | To the Hospital within 24 hours. To the Funeral completely lilled | edicai | (Check only one) | | miner: On the basis | of examin | | | | | occurred | | | | | 6) |

State DHMH 16 Rav 6/95

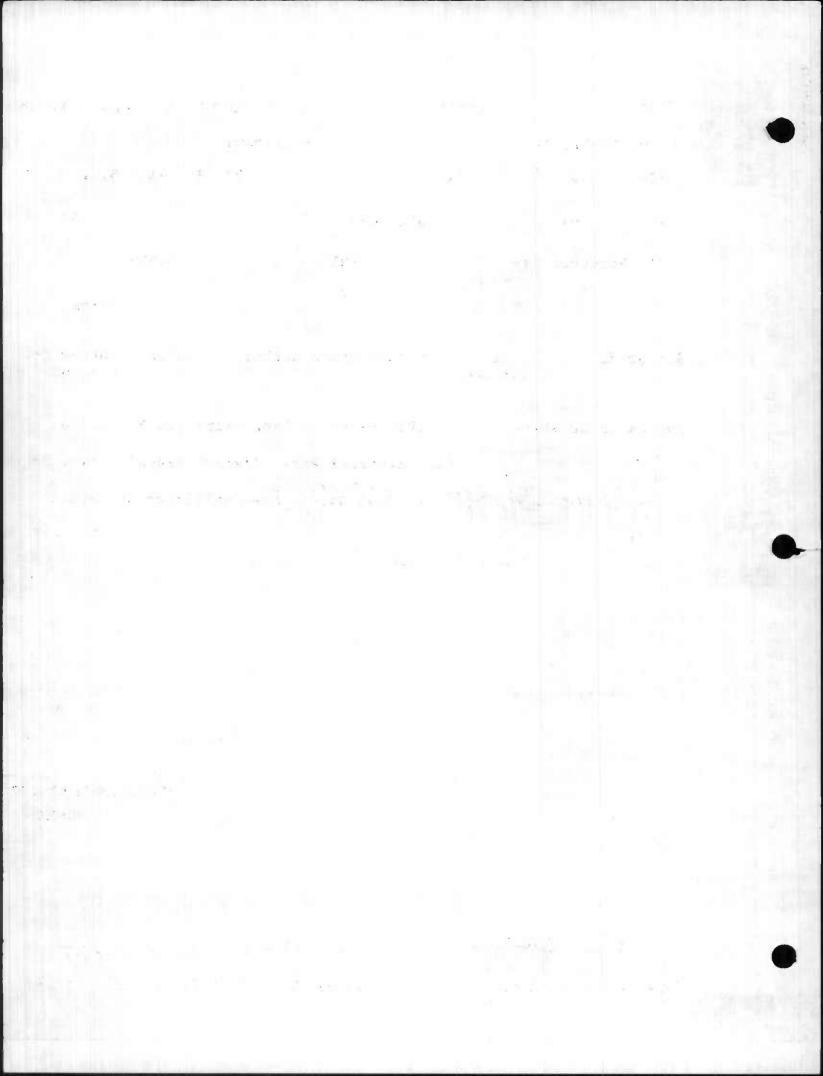
Registrar

29b. Signeture and title of cartifier



Pl , BAltiMORE MD 21202

D40854 April 21, 1999



or Attanding Physician: Division 3

24 hours efter deeth.

Funerel Director: A filled in Hospital edical within 24 hor To the Fune completely fi the

PI

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MIKIN 31. Date filed (Month, Day, Year) State

29b. Signeture and title of certifier

29a. Certifier

(Check only one

my

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

**Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

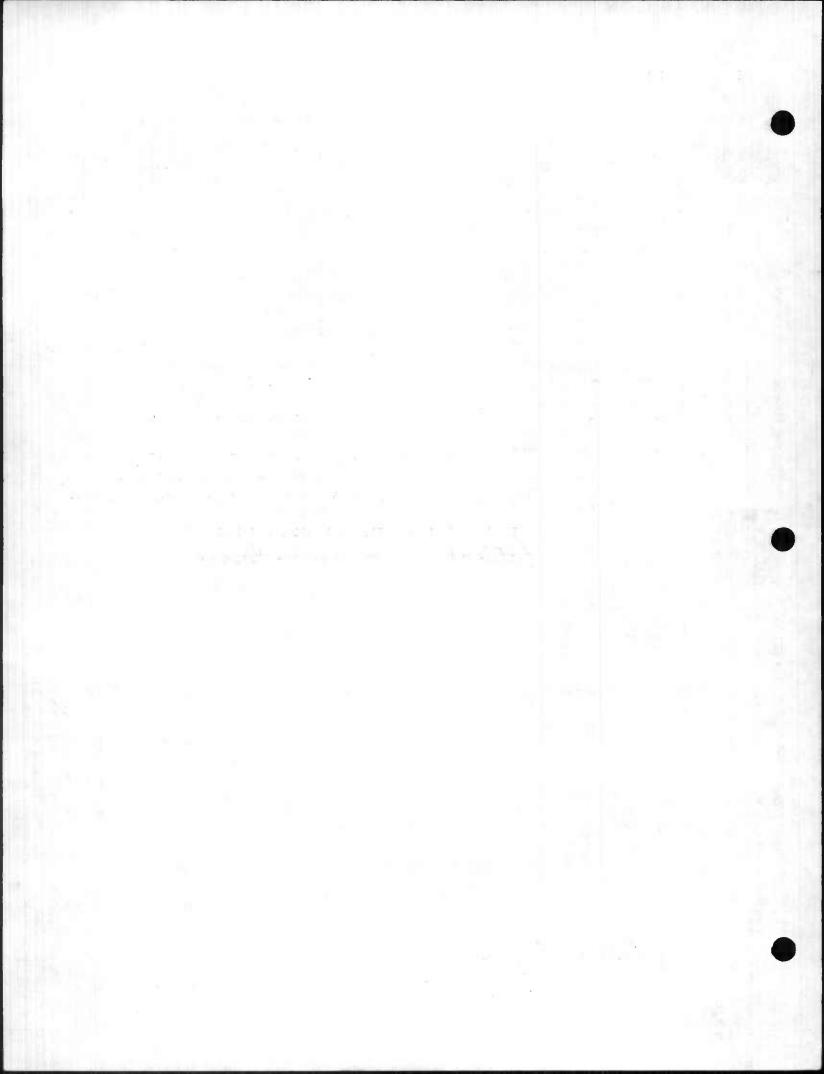
111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Dey, Year)

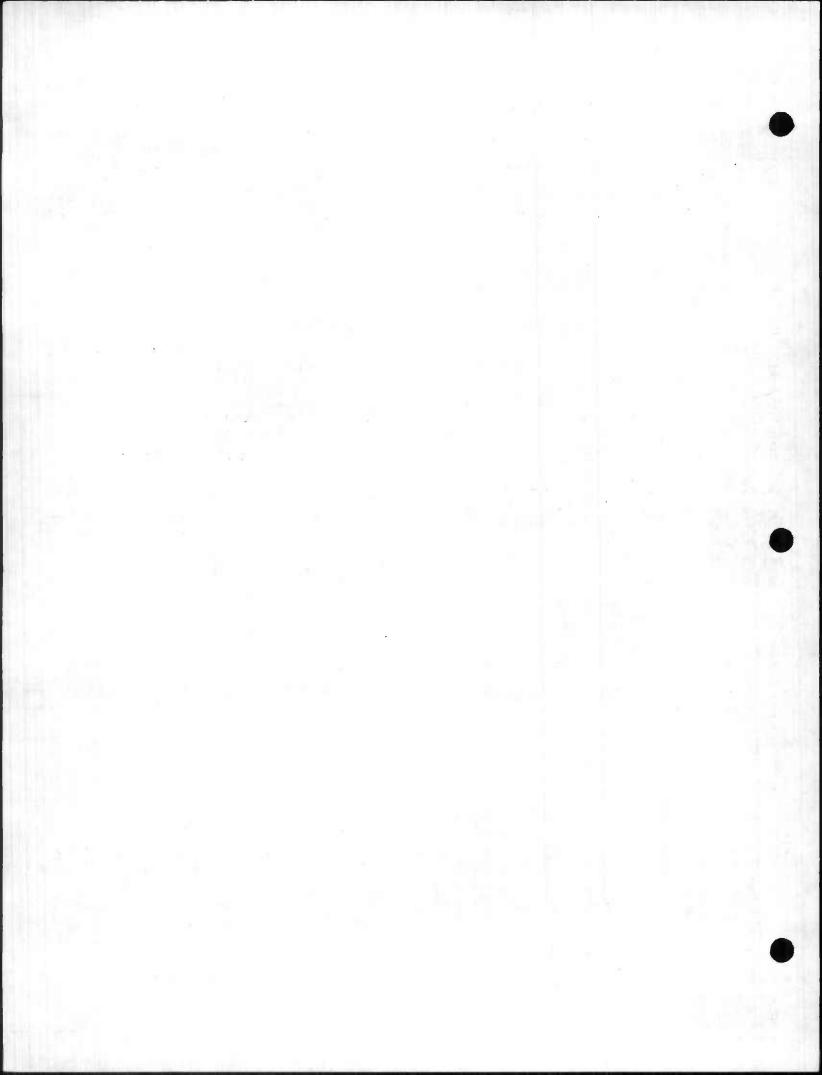
19, 1999

APRIL



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| ASP | LEWIS | | State of M | larylan | | partment of ertificate of | | | giene Reg. No. 🌖 🔾 | 1236 | - 1. |
|--|---|--|--|----------------|----------------------|---|-----------------------------|----------------------------|-----------------------------|--|-------------|
| | | me (First, Middle, La | | | | | | 2. Dete of De | | | of Death |
| Physician /Medical | Deborah | Catherine | Lewis | | | | | APRIL | f6 19 | 999 2:57 | 7 P |
| Examiner | 4e Facility Nema GREAT | | a street and number) MORE MED | | CENTE | R | 4b. City, Town, o TOWSON | r Location of Deat | | of Death | |
| Funeral Director | 5. Social Security 216–58–3 | 590 | 7. Ag | ge (In yrs. 43 | last birthda Yrs. | Months Days | | n. (Month, Da | th ly, Year) 14, 1955 | 9. Birthplace (State Country) Md. | a or Foraig |
| D . | Usual Rasidence | ot Decedent 10b. County | | 10c City | , Town or | ocation | | | | 10d. tnside | City I Imil |
| 72 hours after death with the Maryland natural, or tems 23e or 28e-f show order Examiner must be notified at sted by Funeral Director. | Md. | Anne Aru | mdel | 100. 00 | , rown or | Seve | rn | | | | as 2/2/N |
| oto oto | | | aidei | | | | L11 | | | | 25 - X-X |
| 23e or 28e-f show tell be motified at ral Director | 10e. Street and N 8389 Pior | umber neer Drive | | | | 10f. Zip Code 211 | 44 | | 10g. Citizen of V USA | Vhat Country? | |
| r Name 23. Moer must | 11. Marital Status | | 12. Was Decedent Armed Forcas? | | S. 13 | Was Decedent of If Yes, specify Cul | Hispanic Origin? | (Specify Yes or No | - 14. Rac | e - Amarican Indian, | , |
| 0 = - | 1 | rried 2 Married 4 Divorced | 1 Yas 2 Y If Yas, Giva Year or Datas: | | | 1 ☐ Yes 2 ☐ Yes | | anto moant, etc.) | Specify | ck, Whita, atc. Black | |
| 'naturaf'. Idea Era | | 15. Decedent's Ed | ducation | | 16a. Dec | edent's Usuat Occu | pation | | 16b. Kind of Bu | usiness/Industry | |
| | | cify only highast gra | | F - A | (Give | ra kind of work done DO NOT use retire | e during most of w ed) | rorking | | | |
| omp | Elementery/Sec | condary (0-12) | College (1-4or | 3+) | Homen | aker | | | Private | Families | |
| # 8 8 B | | (First, Middla, Last dward Lewi | | | | | 18. Mother's N Mary | ama (First, Middle Hill | , Maiden Suman | 18) | |
| bus and | | Name/Ralationship (| Type, Print)daug | hter | | iling Addrass (Stree | | | | | |
| f Haalth frem 27 other tr | | | | look D | | | DIIVE D | , | | | |
| 5 = 5 | | Cramation 3 | Removal from State | 0 | ematary, cr | position (Nama of ematory or other plants Cemtery | ace) | Date April 26 | | City or Town, Stata Wne, Md. | |
| Departmen important: any injury ansa. | | 5 Other (Specificants) | • | | | 22. Nama and Addi | ress of Facility | 1 - | | • | |
| Department Important: If eny injury or page. | 1 | 1) | 111 | | | | 1 | | | omes, Inc | |
| | 11. | France | plications that cause ona cause on each li | 1 | | | | | | Md. 2121 | |
| burial-transit burial-transit al Examiner | resulting in death | | b | Due to (o | ras a cons | neclt equence of): | 0 | | | | |
| yslcian and he burial-transit ical Examin | Sequentially list of any, laading to cause. Entar Und Cause (Disease of that initiated even | r Injury | c | | | | | | | | |
| stlending physics is the converging clan/Medic | rasulting in death | Last | d. | Due to (or | as e conse | equence of): | | | | t 1 | |
| fer us | | | | | | | | | | | |
| by the tached | Part tt. Other aign | fficant conditions of | ontributing to death b | out not resu | ulting in the | underlying causa g | iven in Part t. | | tobacco use co | all Probably 4 | |
| b e d | | | | | | | | - | | | |
| page 2 should Completed | | | | | | | | | an autopsy ormed? | 24b. Were autopose aveilable pricompletion of death? | or to |
| page 2 | | | | | | | | 107 | Yes 2 No | 1 2 Yes 2 | P∏ No |
| # 5 a | 25. Wes casa rata | med to medical | | | | | 26 Place of D | eath (Check only | | 1 | |
| irect O | axeminar? | Control of the contro | Hospital: | O 🗆 | ED/Outrati | ent 3KI DOA O | thor | Homa 5 ☐ Rasi | | as (Canaiba) | |
| h. After this c funeral dire tlon: To | 27. Manner of Dea | | 1 ☐ Inpation | ury I | 28b. Time Injury | of 28c. tnj | | | how injury occur | | |
| death. | 2 Accidant | Invastigation | 7 (0 | 99 | 1:5 | O PM 10 | Yes 2,24 No | Autor | nebile | acciden | + |
| 2 2 D = | 3 ☐ Suicide 4 ☐ Homicida | 6 Could not b | 28e. Plece of Inj | jury - At ho | ma, tarm, s | treet, factory, office | | 28f. Location (| Street and Numb | per or Rural Routa Nas and Mal | lumber, |
| od in b | Street Baltimore C | | | | | | | | | | |
| Funer Funer tely fill | 29a. Cartifiar (Check only one) | | ysician: To the best niner: On the basis o and manner st | of my know | wledge, dea | | | ce, and due to tha | cause(s) and mis | annar as stated." | |
| within 2 To the comple | 29b. Signetura en | d title of certifier | and marrier 30 | atou. | | 29c Licer | nse number | | 29d Date signe | d (Month, Day, Year | () |
| 3 - 8 - | | 2 And Or Continue | - 1 | 1 | | | M.E | | APRIL 17 | | , |
| - | al | you 1 | Vla | di | 7, N | P | | | | 1 4000 | |
| O | 30. Name and add | | completed causa of c | | 23a) (Type | | n Street | , Baltim | ore, Mai | ryland 21 | 201 |
| State | 31. Data tiled (Mo | | 32. Registr | rer's Signal | tura | 1 | 22 | | | | |
| State Registrar | | | 999 | perke | F | · pajo - | 1 will | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** LIBERTO CARMELLO 1925 APRIL 1999 /Medical 4a Facility Nama (If not Institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER KANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 219-01-7243 1₺M 2□ F Director July 31.1915 Maryland Usual Rasidance of Decedant the Manyand 10b. County 10c. City, Town or Location 10d. Inside City Limita MD 1 ☐ Yas 2 ☐ No **Baltimore** Baltimore Director 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itsms 23s or 1400 Harberson Road 21228 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after than for the saft and Mental Hopiene.

until fleen 37 is marked other than "naturel", or its until then 37 is marked other than "naturel", or its uny or other traumetic event, the Medical Estatricies. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva White 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0020 Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Certified Government Welder 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Rosa (D'Anna) Giuseppe Liberto 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Liberto (Wife) 1400 Harberson Road, Baltimore, MD 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Memorial Park 4/22/99 Elkridge, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD Lemmer 21228 X 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical **Examiner** Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) physician the burial Box 68760. Physician/Medical Due to (or as a consequence of): for use ate has been signed by the a page 2 should be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yas 2 No þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Piaca of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27, Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation Natural 2 Accident 1 ☐ Yas 2 ☐ No 24 hours after death. 6 Could not be datamined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the F \$ 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifiar W DWees MD D22751 APRIL 19, 1999 Jusque 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) HOSPITAL CENTER, RANDAUSTOWN JUSAN OWENS MD NORTHWEST

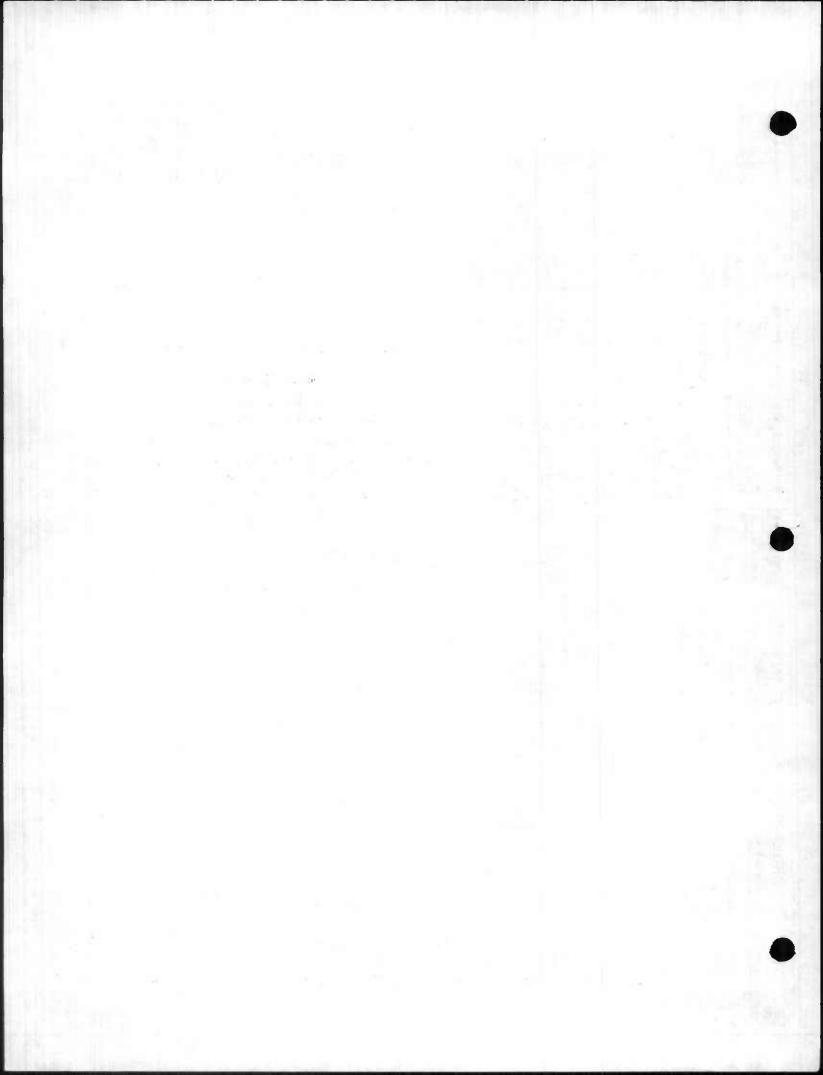
DHMH 16 Rav 6/95

State Registrar

31. Data filed (Month, Day, Year)

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. Registrar's Signatura



Funeral

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Med cal Examiner mast be notified at

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72 hours after

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Physician

/Medical Examiner

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P.O. Box 68760.

Division of Vital Records.

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altimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene (Item: 1 per M.D G-770 4/23/99 reb Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Physician KATHERINE LEVIE KATHERINE 10410 1999 7:10 A.M. APRIL /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Stella Maris/ Mercy Baltimore 5. Sociel Security Number If Undar 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1 M 2 X F Months Deys Hours 214-18-6931 76 Yrs. Maryland Director Usuei Rasidence of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits MD N/A Baltimore 1⊠ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4128 Ardley Avenue 21213 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ₺ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Office Secretary 18. Mother's Neme (First, Middle, Maiden Surnema) 17. Fethar's Neme (First, Middle, Last) (Unknown) Shenk Rose Lynch 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Edward F. Levie 4128 Ardley Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of completely, crometery or other place, Parkwood Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 2/20/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Burvice Licenses John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 Entar the and the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Intervel Between Onset end Deeth immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown ABeres by pertension 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 1 Yes 2. No 1 ☐ Yes 2 ☑ No 26. Place of Deeth (Check only one) STELLA MARIS AT MERCY Be 25. Was case referred to medical Hospitel: Other: 4 Nursing Home 5 Reeldence 8 Nother (Specify) HOSPICE 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 1 2 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and menner as stated.

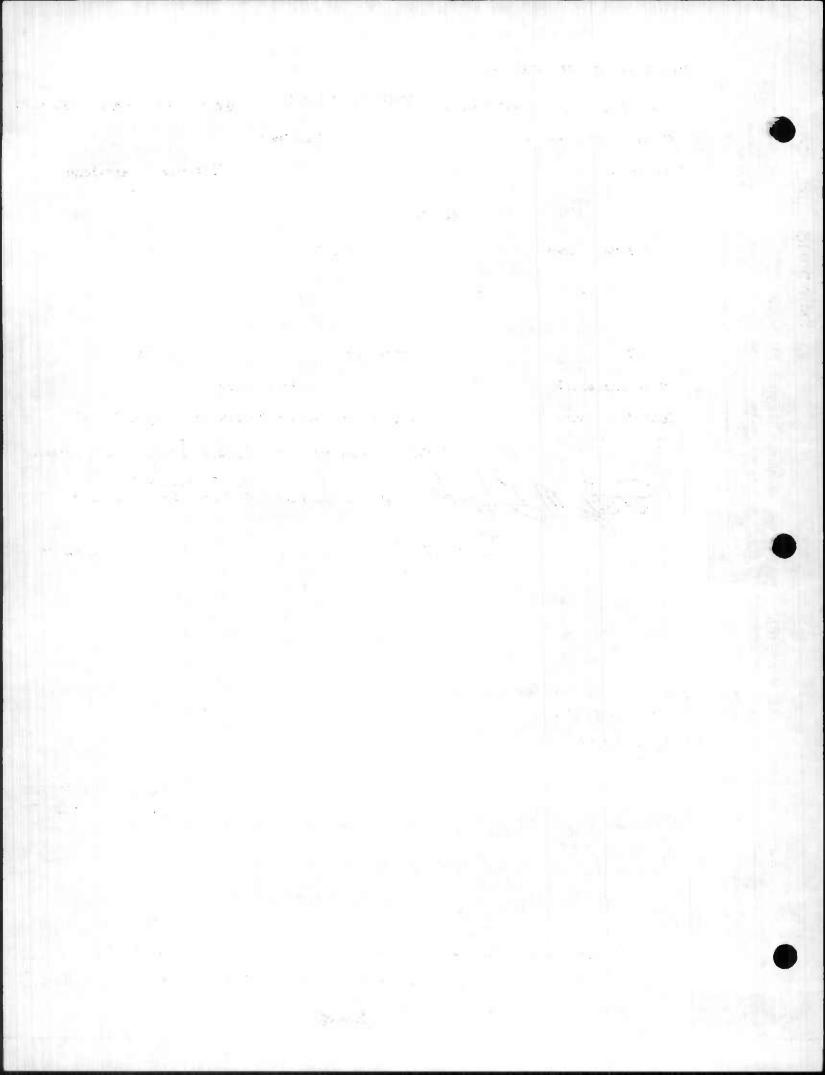
2 Medical Examiner: On the best of examination end/or invastigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and menner stated. 29e. Certifie Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 111 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL #90 STRAIN FRANCIS , 466

Registrar

State

31. Dete filed (Month, Dey, Yeer)
APR 2 3

32. Registrar's Signature



Baltimore, Maryland 21215-0020

filed within Hygiene.

12 should be fi

Pages I

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Nama (First, Middle, Last) **Physician** Thomas /Medical 4a Facility Nama (If not institution, give street and number) Examiner Stella Maris Hospice 5. Social Security Number 7. Ann (In vrs. last hirth **Funeral** 15 M 20 F 56 214 38 3308 Director Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town 7 is merked other than "natural", or items 23s or 28s-f ahow traumatic avent, the Mexical Examples must be notified at Maryland Baltimore Director 10e. Street and Number 8603 Pleasant Plains Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Giva Yeer or Dates: 1 ☐ Nevar Married 2 ☐ Married

| | | | | | Ce | rtificat | e of | Death | | 31 | Reg. No. | | 0001 |
|---|--|---|------------------|--------------|----------------------|---------------------------------------|----------------|--------------|-----------------|---|--------------------------|------------|--|
| 1. Decedent's Name | a (First, Middle | , Last) | | | | A SI | | | | 2. Date of Dec | | | 3. Tima of Death |
| Thomas | | К. | | | 6.82 | Muth | | | | Month April | 22 | 1999 | 10:40 AM |
| 4a Facility Nama (I | f not institution, | give street and nu | mber) | | | | | 4b. City, To | wn, or t | ocation of Death | 4c. Count | y of Death | |
| Stella Ma | aris Ho | spice | | | | | | Timor | nium | | 1 | Balti | more |
| 5. Social Security N 214 38 3 | | 6. Sex 1 → M 2 □ F | 7. Age | (In yrs. las | st birthday) Yrs. | If Under Months | 1 Year Days | | 24 Hrs. Min. | 8. Date of Birt (Month, Da July 2 | y, Year) | Cou | place (State or Foreign intry) yland |
| Usual Residence of | Decedent | | | | | | | | | | | | |
| 10a. Stata | 10b. County | | | 10c. City, | Town or Lo | ocation | | | | | | | 10d. Insida City Limits |
| Maryland | Balt | imore | | | | |] | Baltin | nore | | | | 1 ☐ Yes 2 💢 No |
| 10e. Street and Nur | nber | | | | | 10f. Zip | Code | | | | 10g. Citizen of | What Cou | nlry? |
| 8603 Ple | asant P | lains Rd | • | | | | 2 | 1286 | | 7 30 | Unite | d Sta | ites |
| 11. Maritel Status 1 ☐ Nevar Marri 3 ☐ Widowed | | 12. Was Dec Armed For ed 1 Yes If Yes, Go Year or D | orces? 2 (4No | | 0.07 | Was Deced If Yes, special 1 Yes | city Cut | oan, Mexicar | n, Puerto | pecify Yes or No o Rican, etc.) | 14. Rad Bla Specif | ck, Whita, | can Indian, , atc. White |
| (Spec | 15. Decedent's | s Education grada completed) | | | (Give | dent's Usua kind of wo | rk done | during mos | t of wor | king | 16b. Kind of 8 | usiness/In | ndustry |
| Elementary/Seco 12 | ndary (0-12) | College (| 1-4or 5+ | -) | life. | DO NOT u | rti: | | | | Inte | rior | Design |
| 17. Father's Neme | (First, Middle, L | ast) | | , | | | | 18. Mothe | er's Nan | ne (First, Middle, | Maiden Sumai | ne) | |
| Philip | | J. | | | M | uth | | Fra | nce | s | Koo | ntz | |
| t9a. tnformant's Na J. Phili | | | | | | - | | | | Rd., C | | | |
| 20a. Mathod of Disp 1 ☐ Burial 2 Î 4 ☐ Donation | Cremetion | 3 □Removal from ecify) | Stata | cen | netery, cre | osition (Name matory or count C | ther pla | atory | 4/ | Date 23/99 | 20c. Location Balt | | |
| 21. Signature of Fu | nerel Service L | Suna | u | | C. | AFA S | tep | | Lo | hrmann I | | re, M | nD 21286 |
| 23a. Part1. Enter the shock, or hear | ne disease, or on the disease, or of the disease, o | complications that only one cause on | caused t | he death. | Do not en | ter the mod | le of dy | ing, such as | cardiac | or respiratory a | rest, | | Approximate Interval Between Onset and Death |

Physician /Medical **Examiner**

physician the burial

the

Box 68760.

Division of Vital Records, P.O.

Important: If Itam 27 Is marked other than any Injury or other traumatic avent.

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Completed

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Examiner

Physician/Medical

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Certification:

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting In death)

Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of)

ACQUIRED IMMUNE DEFICIENCY SYNDROME

| | d | | | |
|--------------------------|----------------------------|----------------------------|------------------------|------------------|
| rt II. Other eignificant | conditions contributing to | death but not resulting is | n the underlying cause | given in Part I. |
| | | | | |

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Ware autopsy findings available prior to completion of cause of death?

2 1 No 1 Yes

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE

| 25. | examiner? | to medical |
|-----|-----------|------------|
| 27. | Manner of | □ Panding |

28a. Date of Injury (Month, Day Year) investigetion 6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signetura and little of certifier

APR 23 1999

29c. License number D43725 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

TIMONIUM, MD 21093

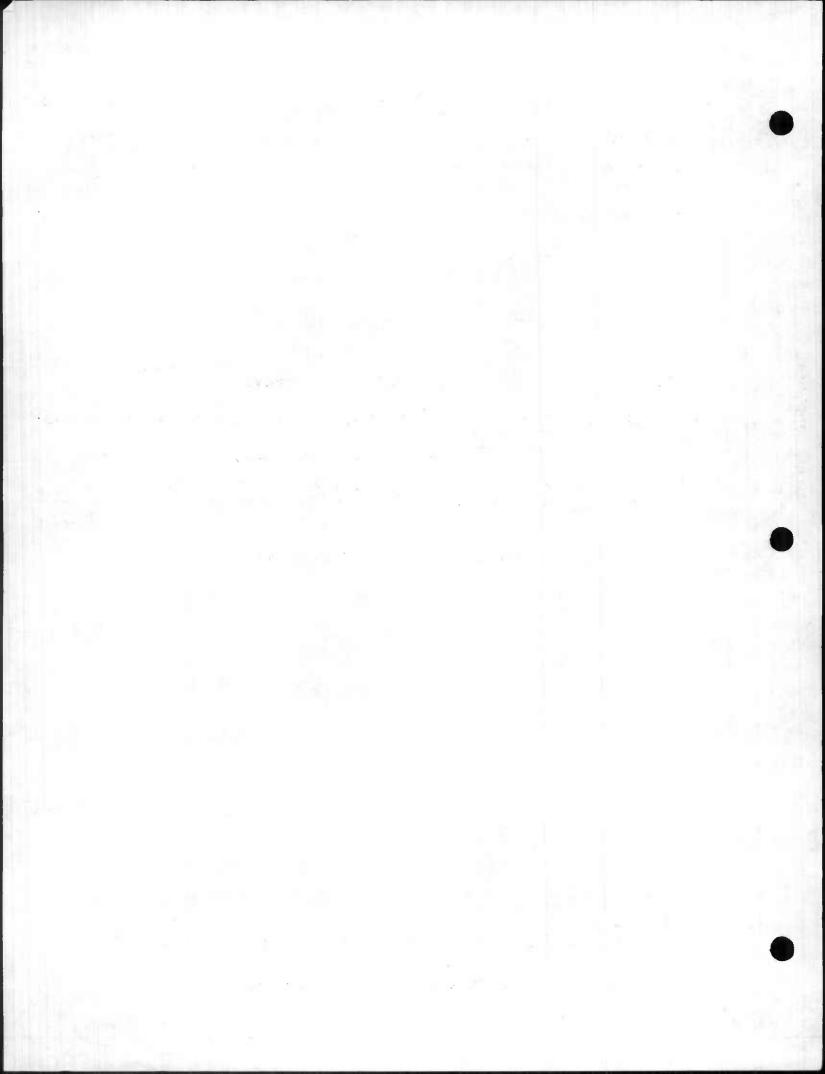
State Registrar

completely

DHMH 16 Rev 6/95

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certified



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 820 pm Month Day **Physician** GEORGE MAGAHA APRIL /Medical 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SECOURS HOSPITAL BALTIMORE If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1₩ 2□ F Months Hours 212-07-5888 84 Director JAN. 28, 1915 Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts "natural", or items 23s or 28s-f show Baltimore Catonsville 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Kenwood Avenue 21228 USA death Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☑ Widowed 4 □ Divorced white nd 2 should be filed within 72 hou lith end Mental Hygiene. 27 is marked other than "natural r traumatic event, I'm Medical E. Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Selector/Warehouseman Grocery permit. Peges 1 and 2 should be file Department of Health and Mental Hy, important: if item 27 is marked othe any injury or other traumatic event, blocs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry L. Magaha Josephine Raymond 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Brenda Caudill - daughter 508 Valcour Rd., Catonsville, Md. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 4/22/99 1 Deurial 2 Cremation 3 Removal from State Meadowridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Elkridge. Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Harl Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. shock, or heart feilure. List only one ceuse on each line. Interval Between Onset and Death Physician · MELANOMA, METASTATIC /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner and I-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequence of): physician a the buriel-Physician/Medical Due to (or as a consequence of): P.O. signed by the e Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CENEBRO VASCULAR ACCIDENT à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy 2 DIABETES MEZLITUS irector, page 2 s AR/AZ FIBRILLATION 1 Yes 2 No 1 T Vas 20 MK Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this After thi 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigetion 2 Accident ofter deeth Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier milles MO

State Registrar THOMAS

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) 32. Registrer's Signature APR 23 1999

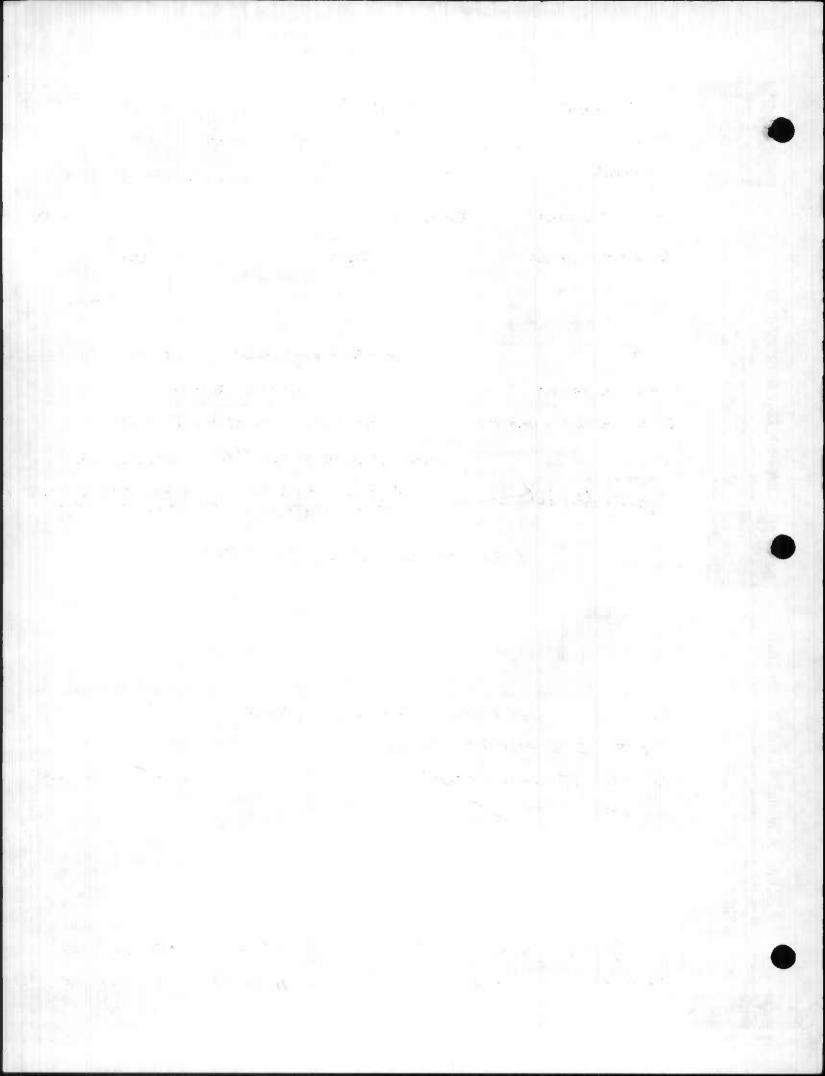
5. MILLER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BON SECONAS HOSPITAL BATIMORE





Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 3 3 6 9

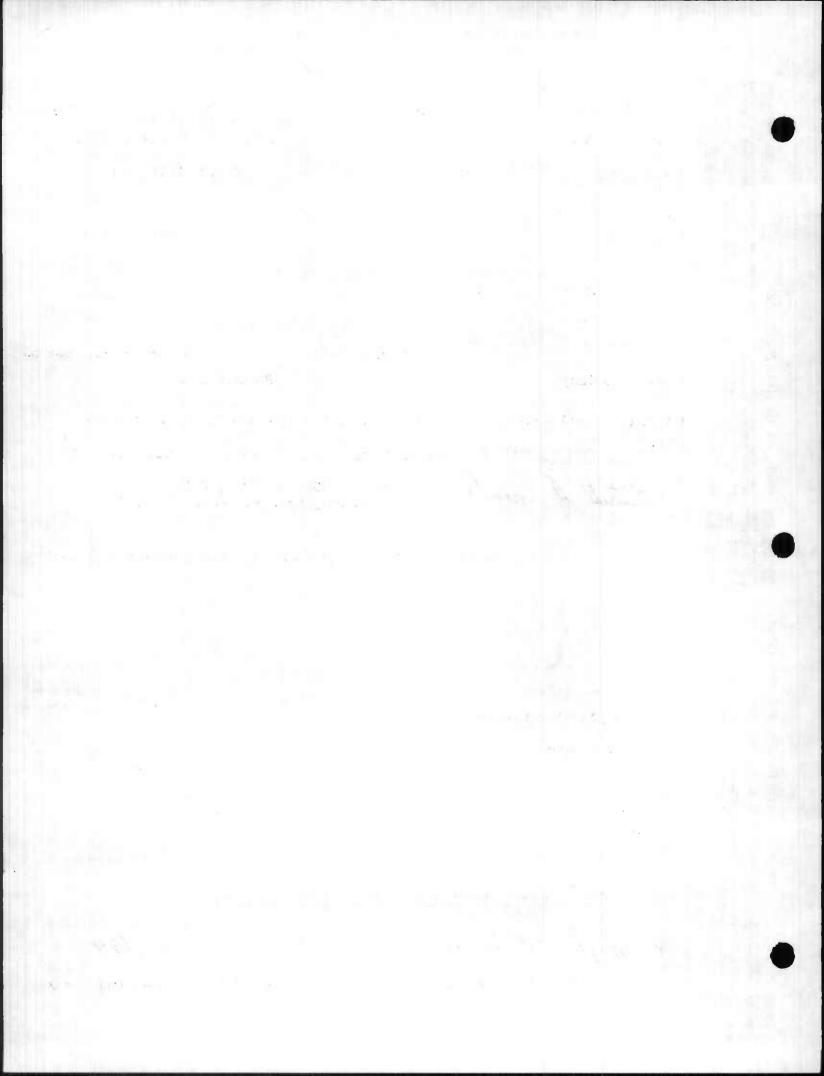
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| Physic /Medi | | | | ames Me | | Matth | ews | | | 2. Dete of De Month Apri | Dey 21, | Year L999 | 3. Time of Death 9:35 PM |
| Exami | ner | 4e Facility Name (| (If not institution, gi | ive street and nu | mber) | | | 4b. City, To | | ocation of Deal | | y of Death Ltimo | ore |
| Funeral Director | | 5. Social Security I 217-10- Usuel Residence of | -8868 | Sex 1☐ M 2☐ F | 7. Age (In yrs. 84 | last birthdey) Yrs. | If Under 1 Yee Months Days | | Min. | 8. Date of Bi (Month, D.) JULY 1 | th sy, Year) 9, 1914 | | place (Stete or Foreign ntry) ryland |
| Maryland of show | tor | 10a. State MD | 10b. County Baltin | more | 10c. Ci | ty, Town or Lo Balt | cation | | | | | 1 | 10d. Inside City Limits 1 ☐ Yes 2X No |
| with the | Direc | 10e. Street and Nu | | 70 | | | 10f. Zip Code | _ | | | 10g. Citizen of | | ntry? |
| within 72 hours after death with the Manyland ena. than "natural", or items 23s or 28s-f show he Madical Examinar must be notified at | by Funeral Director | 2950 F1 11. Merital Status 1 Never Men 3 Widowed | ried 2 Married | 12. Wes Dec Armed For 1 Yes If Yes, Gi Year or D | 2 XNo | | 2122 Was Decedent of f Yes, specify Cu I□ Yes 2▼No | Hispanic Or ban, Mexica | | pecify Yes or No Rican, etc.) | US 14. Re Blo Speci | ce - Americ ack, Whita, | |
| d within 72 hours at glena. ir than "natural", or | Completed by | (Spe | 15. Decedent's E cify only highest gr ondary (0-12) | Education rade completed) College (| 1-4or 5+) | (Give | lent's Usual Occu kind of work done DO NOT use retir | e during mos | st of work | king | 16b. Kind of E | | |
| ges 1 and 2 should be filed within tof Health and Mental Hyglena. If Hem 27 is marked other than or other treumatic event, the Mental Hemister of the Mental Hem | To Be Co | 17. Father's Name | (First, Middle, Las | • | 3 | Ца | iborer | | | a (First, Middle V. Ne | , Maiden Suma | | mpany |
| ges 1 and 2 sho t of Health and If Nem 27 Is me or other treums | | | Atkinso | | e e | 2950 | Freew sition (Name of | | | imore. | MD 2 | 1227 | |
| P F F F | | 1 Donation | Cremetion 3 [5 ☐ Other (Special | ify) | Stete | etro Cr | ematory or other pl | , Inc. | | | Baltin | nore, | , MD |
| pemit. Pag Department Important: I eny Injury o | | 21. Signatury of P | unlA | . 80 | // | 1 2 | Name and Addition of the Name and Addition of | doric | I D | d Dal | timone | and, | Inc. 21228 |
| Physician /Medicale Examiner physician and cities of the principal cities as t | VMedical Examiner | shock, or hei Immediete Cause disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Und cause (Disease or that initieted event resulting in death) | (Final on onditions, mediate entying injury is | a | Due to (d | 2 LLL or as a consequence of esta consequence | uencoloi): | | | | | | Approximata infraval Batween Onset and Deeth I Clouy Several yx |
| death e atter | Physician/W | Part II. Other eigni | ficant conditions | contributing to d | eath but not res | sulting in the ur | nderlying cause g | liven in Part | l. | | tobacco use c | | o the cause of death |
| e law requires has been sign ge 2 should be | Completed by F | Pepti | c VIce | r Dis | eon | Dools | D | luti. | - Cnu | perl | s an autopsy ormed? | av co of | ere eutopsy tindings railable prior to mpletion of cause deeth? |
| After | After this certific funeral director. | 25. Wes case reference axaminer? 1 Yes 2 2 27. Manner of Dear 1 Neturel 2 Accident | YNo | 28a. Data (Mon | Inpatient 2 of Injury | ER/Outpatien 28b. Tima of | t 3□ DOA O | 26. Plac | ursing He | th (Check only | Yes 2 M/No ona) idence 6 □Ot how injury occu | har (Specil | yes 2□ No (/y) |
| To the Hospital or Attanding Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process. | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not I detarmined | 208. Place | of Injury - At hing, etc. (Speci | | eet, fectory, office | | | | (Street and Num wn, Stete) | ber or Run | al Route Number, |
| To the Hospital within 24 hours of the Funeral Completely filled | Medical | 29a. Certifier (Check only one) | 1☑ Certifying Pi 2☐ Medical Exa | miner: On the b | | | restigation, in my | opinion, de | | | date end place | , and due to | o tha causa(s) |
| T V TOO | * | 29b. Signature end | uma J | Rayonus | | | 20 | 754 | + 1 | | 29d. Dele sign | 22 | , 1999 |
| | | 30. Name and edding CETTI 31. Date filed (Mon | MA RH | 93A-14 | sa of death (Iter 367 H | ollins | Ferry | Rd, | Bu | Chrone | M)- | 2122 | -7. |
| Sta | ite | O1. Date med (MO) | APR 2 | 3 1999 | iogistiars Signi | ممر | 9. hs | ack! | / | | | | |

W to tending Personal Letint Pompe Dedner There

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 3 7 0

| | | | | | Cer | tificate o | f Death | | Reg. No. | | | | | | | |
|--|-----|--|---|---|--|--|--|--|--------------------------------|---------------------------------------|--|--|--|--|--|--|
| Physician | | . Decedent's Name (First, Middle, L. | ast) | | | | | 2. Dete of De Month | eath Dey | Yeer | 3. Time of Dea | | | | | |
| /Medical | | CARMELLA | М. | | LEOD | | | | 19,1999 | | 12:25F | | | | | |
| Examiner | 48 | Fecility Neme (If not Institution, gi | |) | | | | r Location of Deet | | | | | | | | |
| | | 1041 A Spa Road | | | | If Under 1 Ye | Annapol ar If Under 24 Hi | | Anne | | | | | | | |
| Funeral Director | 1 | | 1 M 257 E | ge (In yrs. 81 | lest birthdey) Yrs. | Months Dey | | | 1917 | 9. Birthpl Count New J | ace (State or Fo ry) ersey | | | | | |
| show | | 0a. State 10b. County | | 10c. Cit | y, Town or Loc | ation | | | | 10 | d. Inside City Li | | | | | |
| to other | | MD Anne Ar | undel | | Annapol | is | | | | | 1√ Yes 2□ | | | | | |
| 23a or 28a-f sho unt be notified at rai Director | 10 | 0e. Street and Number | | | | 10f. Zip Code | • | | 10g. Citizen of V | What Count | ry? | | | | | |
| 23a or 28a-f show unt be notified at | 3 | 1041 A Spa Road | | | | Anna | polis | | USA | | | | | | | |
| if, or items | 5 | 1. Marital Status 1 Never Married 3 Merried 3 Widowed 4 Divorced | 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Detes | ? I No | | /as Decedent of Yes, specify C | of Hispanic Origin? outpan, Mexican, Pue | Specify Yes or No erto Rican, etc.) | Bled | e - America ck, White, e /: Whi | etc. | | | | | |
| "natural", polical En | | 15. Decedent's E (Specify only highest gi | Education | | 16a. Deced | ent's Usual Occ | cupetion ne during most of w ired) | rorkina | 16b. Kind of B | usiness/ind | ustry | | | | | |
| | | Elementery/Secondary (0-12) | College (1-40) | 5+) | | | | OTK, II G | | | | | | | | |
| Hygier the the Cor | 3 | 12 | | | Boar | d Mecha | | | | | gineeri | | | | | |
| and Mental Hygiene. s marked other than turnatic event, or Me To Be Compi | 1 G | 7. Father's Name <i>(First, Middle, Las</i> Saetano DiGangi | it) | | | | | _{ame (First, Middle} osalie Di | | n <i>e)</i> | | | | | | |
| and M aumet | | 9e. Informant's Name/Relationship | (Type, Print) | | 19b. Meilin | Address (Stre | eet end Number or i | Rural Route Numb | er, City or Town, | State, Zip | Code) | | | | | |
| trait | C | hrum F. McLeod - | - Husband | | Box 2 | 1310 , | Stokes Ro | oad, Medi | ord, NJ | 0805 | 5 | | | | | |
| Department of Health and Mental Hygiene. Important: if item 27 is marked other than any highry or other traumatic event, train once. To Be Comp | 20 | 0e. Method of Disposition 1 | | C | emetery, crem | ition (Neme of etory or other p emorial | Park | Date 4/22 | 20c. Location - Pennsa | | | | | | | |
| Departm importa any inju | 2 | 1. Signeture of Funeral Service Lice | ansee | 1 | H | ardesty | fress of Facility Funeral Ly Ave. | | | 1401 | | | | | | |
| e attending physician and ad for use as the bunel-transit sician/Medical Examiner | | Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury net initiated events esulting in death) Last | c | Due to (o | r as e consequ r as e consequ r es e consequ | uence of): | | | | | | | | | | |
| D 8 2 | | | d | | | | | | | | | | | | | |
| d for use | P | art II. Other significant conditions | contributing to death | hut not res | ulting In the un | deriving cause | given in Pert I | 23h, Did | tobacco usa co | ntributa to | the cause of de | | | | | |
| ed by the detach | | | | | onling in the di | 3011y#1g 04030 | givon in rock i. | | Yes 2 No | | | | | | | |
| 2 should | _ | Hypert | + | | | | | | an autopsy ormed? | con | ore eutopsy findi pileble prior to appletion of caus deeth? | | | | | |
| is certificate he director, page | | | | | | | | 10 | Yes 2 No | 10 | Yes 2□ No | | | | | |
| entific ector Be | 2 | 5. Was case referred to medical exeminer? | | | | | | eath (Check only | 900 | | | | | | | |
| | | 1 ☐ Yes 2 ☐ No | Hospital: | | ER/Outpatient | 3L DOA | | Home 5 Res | | | ') | | | | | |
| To dire | | | | | | | | 28d. Describe | how injury occur | red | | | | | | |
| € @ | | Z LI ACCIDENT | 28f. Location (City or To | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) | | | | | | | | | | | | |
| € @ | | 2 Accident 3 Suicide 4 Homloide | 26e. Plece of In building, e | ic. (Specif | " | 29e. Certifier (Check only (Ch | | | | | | | | | | |
| £ @ | 2 | 3 Suicide 4 Homloide 6 Could not 1 determined | hysician: To the bes | of my kno | wledge, death | occurred at the estigetion, In m | time, date end pla y oplnion, deeth oc | ce, end due to the curred et the time, | ceuse(s) and mo | enner as st end due to | ated. the cause(s) | | | | | |
| € @ | | 9e. Certifier (Check only (Che | building, e | of my kno | wledge, death | estigetion, In m | time, date end pla y opinion, deeth oc ense number | ce, end due to the curred et the time, | ceuse(s) and modate end plece, | end due to | the cause(s) | | | | | |
| in 24 hours after deeth. he Funeral Director: After th pletely filled in by the funeral edical Certification: | | 9e. Certifier (Check only one) Suicide Government G | hysician: To the bes | of my kno | wledge, death | estigetion, In m | y opinion, deeth oc | ce, end due to the curred et the time, | date end piece, | end due to | the cause(s) | | | | | |

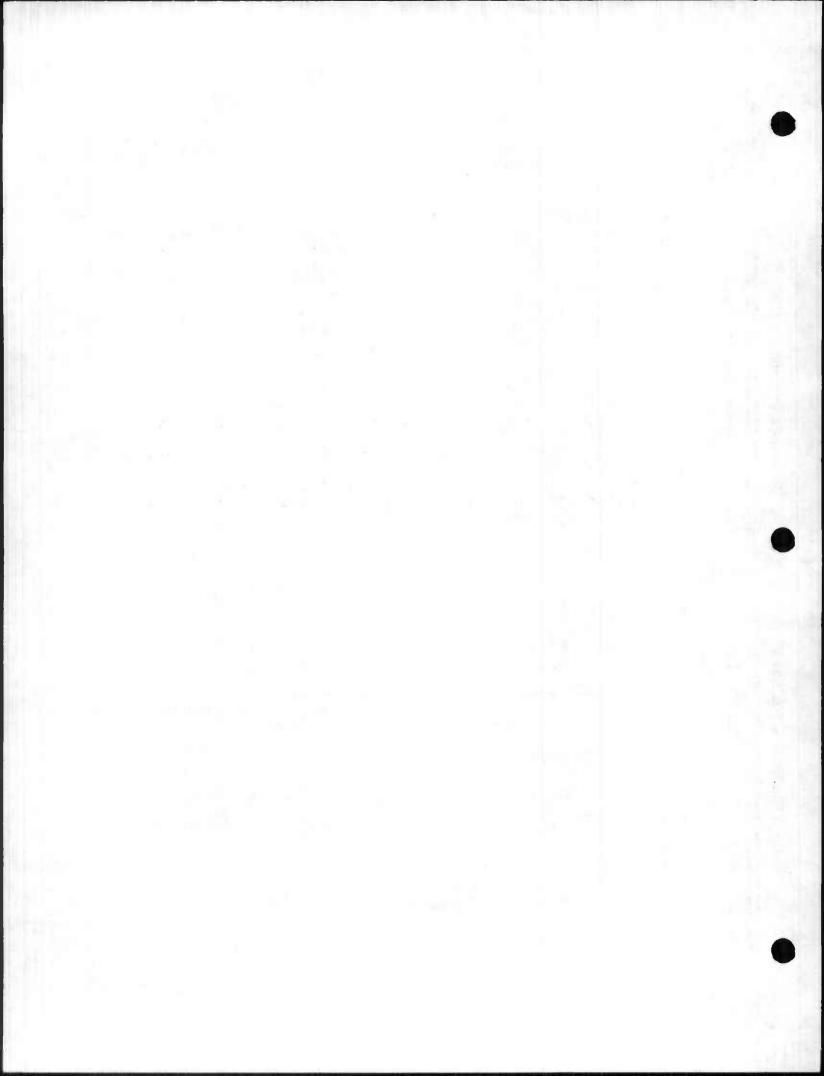


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| 3-003 | | | State | OI Waiy | (| Certifica | te of | lealth an Death | u Mena | | g. No. | | 337 | |
|----------|--|-------------------------|-------------------------|----------------------------------|------------------|------------------|------------------------|-----------------------------------|----------------|-----------------------|------------------------------|------------|--|-------------|
| hysician | 1. Decedent's Neme (Fire | st, Middle, La | st) | | | | | | 2. Dete | of Death | Day | Year | 3. Time o | f Death |
| /Medical | John Edward | Meale | y | | | | | | AP | RIL | 20, 19 | | 1544 | PM |
| aminer | 4a Facility Name (If not i | | | number) | | | | 4b. City, Town | | f Death | 4c. County | of Death | | |
| | #2 WILLOW 5. Social Security Number | | | 7 Ass (In | una lant histh | eta) If Und | er 1 Year | ANNAPO | | of Dieth | ANNE | | | |
| al or | 419-07-1258 | | □M 2□ F | | yrs. last birth | Months | | | Min. (Mo | of Birth nth, Day, | Year) , 1921 | Cour | olaca (State ontry) bama | or r-oreign |
| | Usual Residence of Dece | | 74 | 11 | | | | | Jour | e 10, | ,1921 | MIG | Dalla | |
| | | . County | | | . City, Town | | | | | | Ŷ | 1 | 10d. inside C | |
| Director | MD Ar | nne Arı | naer | | Annapo | lis | | | | | | | 1 Yes | 2 No |
| 5 | 10e. Street and Number | hwook | | | | 10f. Z | ip Code | 2.1 | | 10 | g. Citizen of W | hat Cour | ntry? | |
| | 2 Willow St | rreer | 40 M. D. | | - 110 | 40.11/ | 2140 | | 2 (0 | - No | USA | Amada | nan tadian | |
| | 11. Meritel Stetus 1 Never Merried | 20 Married | Armed F | cedent Ever Forcas? 2 No | in U,S. | If Yes, sp | ecify Cub | Hispanic Origin an, Mexican, P | uerto Rican, e | tc.) | | k, Whita, | etc. | |
| | 3 □ Widowed 4 □ [| | ff Yes, C | Detes: WW | II | 1 🗆 Yes | 200No | Specify: | | | Specify: | Wh | ite | |
| | | Decedent's Ed | ducation | - | 16a. C | ecedent's Us | nel Occur | oation | | 1 | 6b. Kind of Bu | siness/In- | dustry | |
| | (Specify on Elementery/Secondery | | da completed College | (1-4or 5+) | - 7 | ife. DO NOT | ork done use retire | pation during most of d) | working | | | | | |
| | 10 | | | | Ow | ner/Op | erato | T | | | Sign Co | | У | |
| | 17. Fether's Nema (First, John Edward | | | | | | | | | | laiden Sumam | 9) | | |
| | | | | | | | | Rada | Bartl | | | | | |
| | 19a. Informent's Neme/F Mary Callawa | | | F-0 | | | | eet, An | | | | | o Code) | |
| | 20e. Method of Disposition | | cy wii | | Ob. Plece of E | Disposition (N | ame of | | Date | - | Oc. Location | | own, Stete | |
| | 1 Buriel 2 □ Cre | metion 3 [| | n Stete | Hillcr | est Cer | other pla netel | ce) Cy | 4/24 | | Annapol | | | |
| | 4 Donetion 5 D | | | | 11 | | | ess of Fecility | | | | | | |
| | · Rot | 10 | 1/1 | 2.1 | // | Harde | sty I | Puneral | | | | | | |
| - | 23a. Pert1. Enter the dis shock, or heart failu | aesa, or com | olications the | t caused tha | death. Do no | 12 Ric | dgely | Ave. | Annapo | lis, | MD 21 st. | 401 | Approxima | te |
| Examiner | diseese or condition resulting In deeth) Sequentially list condition if any, leeding to immediause. Enter Underlying Cause (Diseese or injury | ns, ete | b | Due | to (or es a co | nsequence of |): | round | ot n | 1901 | | | | |
| | Cause (Disease or injury that initiated events | ~ | c | Due | to for as a co | nsequanca of | l • | | | | | | | |
| | resulting in death) Lest | | | Due | 10 (01 93 9 00 | insequanioa or | ,• | | | | | ì | | |
| | | | d | | | | | | | | | 1 | | |
| | Pert II. Other significant | conditions o | ontributing to | deeth but no | t resulting in t | he underlying | causa gi | ven in Pert I. | 23 | b. Did tot | bacco use cor | tribute t | o the cause | of death? |
| | | | | | | | | | | 1 🗌 Ye | 8 2 No | 3 Pro | bably 4 |] Unknow |
| | | | | | | | | | 24 | a. Wes an | eutopsy | 24b. W | ere sutopsy | findings |
| | | | | | | | | | | parform | ned? | CC | vailable prior ompletion of deeth? | |
| | | | | | | | | | | LIMI' | | | Yes 2 | 1 No |
| | 25. Wes case referred to | medical | | | | | | 26. Place of | Deeth (Chec | | | | 7 100 22 | |
| | exeminer? 1⊠ Yes 2 No | | Hospitel: 1 | Inpatient | 2 ER/Out | atient 3 0 | Ot Ot | her | | | nce 6 Oth | er (Speci | fy) | |
| | 27. Menner of Deeth | Pending | 28a. Det | e of Injury onth, Dey Yea | 28b. Tir | ne of ury | 28c. inju Wo | | 28d. De | scribe ho | w injury occurr | ed | | |
| | 2 Accident | | 30 M | | Yes 20 No | Subj | rect | shot s | elt | | | | | |
| | 3 Suicide 6 L 4 ☐ Homicide | Could not be determined | 208. PI6 | ce of Injury - ding, etc. (S) | At home, fam | n, street, fecto | ry, office | VIII. | | | reet and Numb , Stete) #2 | | | |
| | | | | RE | siden | | | | Ann | apolis | s, Ma | ryla | ind | |
| | | | niner: On the | basis of exa- | | | | me, date and popinion, deeth | | | | | | s) |
| | 29b. Signeture and title of | of certifier | ena me | nner steted. | | 2 | 9c. Licen: | se number | | 29 | d. Dete signed | d (Month. | Dav. Year) | |
| | 11- | 10 | 4 4 | 1 | 15 | | OC | | | | 1000 | 21,] | | |
| | 30. Neme and address of | person who | completed car | use of death | (Item 3a) It | yne Print) | | | | | | | | |
| | Strohen | 5. 6 | 2 ade | 4 | | | pet | Baltin | nore N | larvil | and 212 | 201 | | |
| | 31. Date filed (Month, De | y, Year) | | Registrer's S | Signature | | | اللايا عمص | To the second | Y A | MAL CIA | .U.L | | |
| r | Λ | PR 23 | 1000 | 1 | west. | 19 | 100 | 11 | | | | | | |

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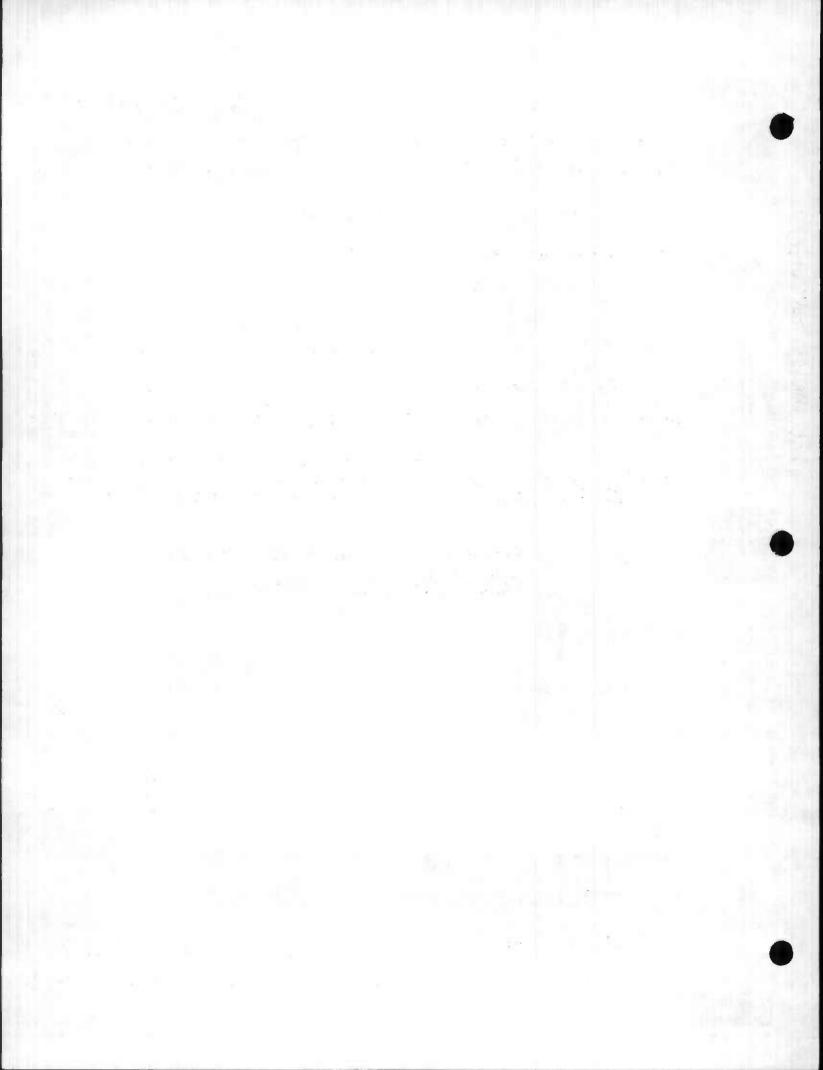
ORIGINAL



| | | | | | or ividity idi | | rtificate o | | d Mental H | Reg. No. | 13 | 372 | |
|-------------------------------|--|--|--|--|--|---|--|---|--|--|--|--|--|
| | | | nt's Name (First, Middl | le, Last) | | | | | 2. Dete of I | Deeth | Yeer | 3. Time of Death | |
| | Physician /Medical | | 1 | Annette | Grace | Nalev | anko | | Apri | 20 | 1999 | 12280 | |
| | Examiner | 4 - Cardilla | Neme (If not institution | n, give street end n | umber) | | | 4b. City, Town | , or Location of De | eth 4c. Coun | y of Deeth | , | |
| | 8: [_L _L] | | la Maris | | | | W11-34 V- | | imore | N, | | | |
| | Funeral | | Security Number | 6. Sex 1 ☐ M 💥 ☐ F | 7. Age (In yrs. 5 0 | . lest birthdey) Yrs. | If Under 1 Ye Months De | | Min. (Month, | Birth Day, Year) | | ce (State or Foreign | |
| | Director | | -66-6004 | | | | | | APR O | 2, 1949 | Washin | gton, DC | |
| | /land | 10a. Stete | 10b. County | 1 | 10c. Ci | ity, Town or Lo | ocation | | | | 10d | I. Inside City Limits | |
| | Man | MD | Bal | ltimore | | Ca | tonsvi | 11e | | | | 1 ☐ Yes 2 No | |
|) | hurs effer death with the Maryland alt, or items 23s or 23s-f show Exercises must be notified at the Eumeral Director. | 10e. Stree | t and Number | | | | 10f. Zip Cod | е | | 10g. Citizen of | Whet Country | /? | |
| - | 15 will | 1920 | Rollings | wood Roa | ıd | | 212 | | | U.S | SA | | |
| | ifter death v | 11. Marite | Status | Armed F | cedent Ever in U | J,S. 13. | Wes Decedent of If Yes, specify C | of Hispenic Origin Juban, Mexican, P | ? (Specify Yes or uerto Rican, etc.) | No- 14, Re BI | ce - American | | |
| 0 | or H | | ever Married 2 Marr | If Yes. G | | | 1□ Yes 2√21 | | | Spec | | | |
| Č | hours hours | | idowed 4 Divorced | | Detes: | 100 Door | dont's Havel Os | | | 16h Vind of | Business/Indu | | |
| 21215-0020 | ed within 72 ho bygiene. ner than "nature ft, the Medical | | (Specify only highe | nt's Education est grade completed | | (Give | dent's Usuel Oc kind of work do DO NOT use rei | ne during most of | f working | | | | |
| 1 5 | the interest | Elemen | tery/Secondery (0-12) 2. | College | (1-4or 5+) | Ass | istant | Manag | or | | lesale | ompany | |
| | tal Hyg | | 's Neme (First, Middle, | Last) | | | | 18. Mother's | er Neme (First, Midd | die, Meiden Sume | me) | ompatry | |
| - | Menta | | Ludger l | P. Chare | est | | | | Dorothy | Jankos | ski | | |
| Manyland | is 1 and 2 should be filed within 72 hours effer death w if Health end Mental Hygiene. Item 27 is marked other than "natural", or Items 23s other traumatic event, the Modesi Evan her main | 19e. Infor | ment's Neme/Reletions | | | | | | | | | | |
| | and saith n 27 | Doro | thy Chare | est/Moth | | | | | | | | ID 21228 | |
| 2 | | | od of Disposition | 3 □Removel from | 20b. I | Placa of Dispo cemetery, crei | osition (Neme of metory or other | plece) | Dete | 20c. Location | - City or Town | n, Stete | |
| | . Pages iment of teats if the jury or of | | onetion 5 Other (S | | | | | , Inc. 4 | 1/21/99 | Balt | more. | MD | |
| Raltimore | pemit. Page Depertment of important: if eny injury or page. | 21. Signe | Ive II Funerel Service | Licopeno | | | | | | | altimore, MD | | |
| | | N 2 | ×1. 1 A | Gun | th | č. | remati | | iety of | | nd, Inc. | | |
| - | | | | Gregoro | | 2 | 99 Fre | dress of Facility On Soc derick | Rd. Ba | Maryla 1timore | and, I | 21228 | |
| | | 23a. Pert | dward A. 1. Enter the disease, or kk, or heert failure. List | Gregoro r complications thet | caused the dee | 2 | 99 Fre | dress of Facility On Soc derick | Rd. Ba | Maryla 1timore | and, I | 21228 Approximete Intervel Between | |
| | Physician | 23a. Pert shoo | Enter the disease, or ck, or heert failure. List | Gregoro r complications thet | caused the dee | 2 | 99 Fre | dress of Facility On SOC derick dylng, such es ca | Rd. Ba | Maryla ltimore yerrest, | and, I | 21228 Approximete | |
| 9 | | 23a. Pert shoo | Enter the disease, or ck, or heert failure. List e Cause (Finel or condition | Gregoro r complications thet | caused the deer each line. | oth. Do not ent | 99 Fre | dress of Facility On SOC derick dylng, such es ca | Rd. Ba | Maryla ltimore yerrest, | and, I | 21228 Approximete Intervel Between | |
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| | Physician /Medical Examiner | 23a. Pert shoot Immediate disease or resulting in the shoot of the sho | 1. Enter the disease, or k, or heert failure. List e Cause (Finel ir condition in deeth) ally list conditions, ding to immediate inter Underlying isease or Injury ed events | Gregoro r complications thet | Caused the dee | oth. Do not ent | egg Free ter the mode of a Ca quence of): | dress of Facility On SOC derick dylng, such es ca | Rd. Ba | Maryla ltimore yerrest, | and, I | 21228 Approximete Intervel Between | |
| 6876 | Constitution of the principle of the pri | 23a. Pert shoot Immediate disease or resulting if any, lea cause. Er Ceuse (D) that initiat resulting if any lea cause. Er cause (D) that initiat resulting if any lea cause. Expense (D) that initiat resulting if any lea cause. Expense (D) that initiat resulting if any lea cause. Expense (D) that initiat resulting if any lea cause. Expense (D) that initiat resulting if any lea cause. | 1. Enter the disease, or k, or heef failure. List e Cause (Finel r condition n deeth) ally list conditions, ding to immediate nter Underlying isease or Injury | Gregoro r complications thet | Caused the dee | 2 Ven | egg Free ter the mode of a Ca quence of): | dress of Facility On SOC derick dylng, such es ca | Rd. Ba | Maryla ltimore yerrest, | and, I | 21228 Approximete Intervel Between | |
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DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Biack Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 18,1999 OUEEN E. PRICE 11:15pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE 7407 MARSTON RD. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7-26-24 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2K)F Months Devs Hours 212-42-3780 74 Yrs. N.C. Director **Usual Residence of Decedent** the Maryland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or flams 23s or 28s-f show with injury or other traumatic event, the Medical Examiner must be notified at pages. 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD. BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 MARSTON RD. 21207 USA Funeral 12. Was Decedenl Ever in U,S. Armed Forces? 1 ☐ Yes ② QNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK p 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN HAIR CARE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) VICTOR H. HINES MARTHA ELLERBE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY GALLOWAY (DAUGHTER) 7407 MARSTON RD. RANDALLSTOWN, MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4-23-99 LAUREL, MARYLAND MD. NATIONAL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PRIERIOSCO EROTIC CARDIO VASCALAR

Due to (or as a consequence of):

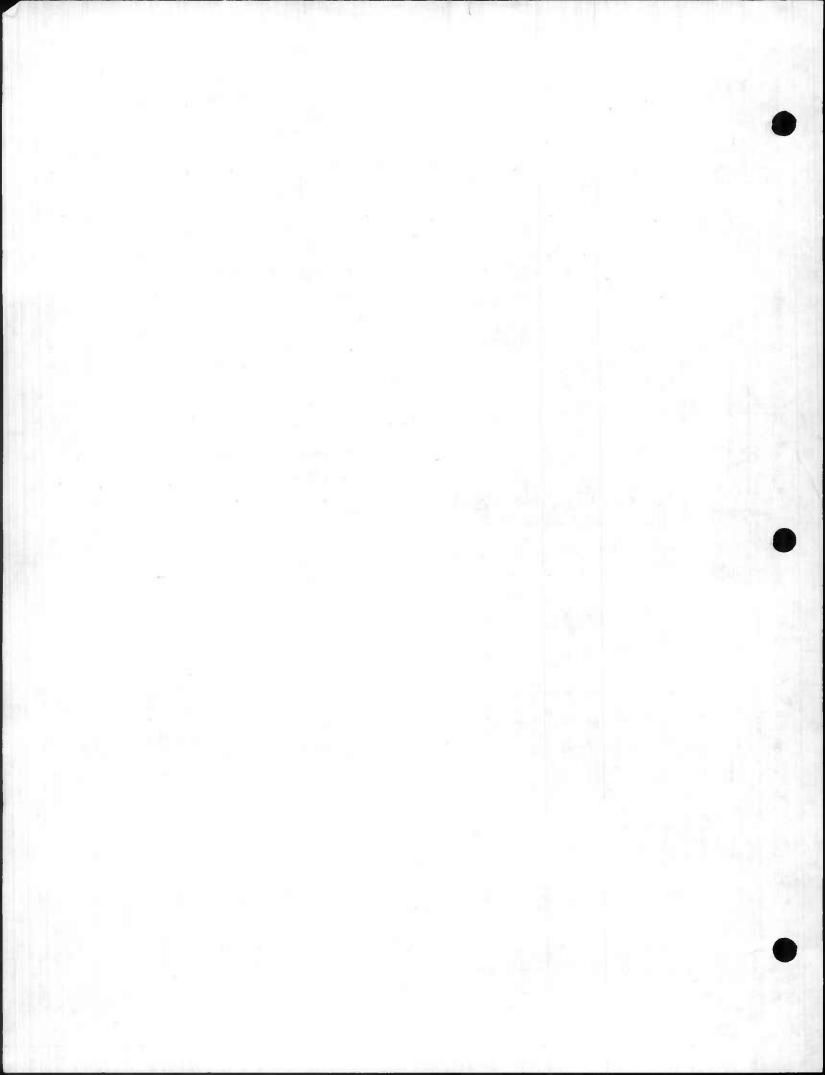
DISPASE Examiner by Physician/Medical Examiner physicien end the buriel-transit or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequenca of): 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Records, 24a. Was an autopsy performed? Completed 24b. Were autopsy findings available prior to CONTRACTURES completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vitai 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

Be Funeral Director: After the function of the functi 1 Yes 2 No 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) D25052 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYET 1AFEEZ Cross/ 20 32 Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year)



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PALMER JAMES 1:22 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 15€M 2□ F Months Days 217-56-7512 Usuel Residence of Decedent M.D. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Sidney Ave 21230 U.S.A. 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed A Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flementery/Secondary (0-12) College (1-4or 5+) Chaffeur Baltimore City 11th grade NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nathaniel Pope Dorothy Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Palmer-Mother
20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)

20b. Place of Disposition (Name of cametery, crematory or other place) 1 Buriel 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Zion Cemetery
22. Name and Address of Facility
March F/H West 4/27/99 Baltimore, Md 21. Signature of Funeral Servica Licen Ruma max 4300 Wabash Ave, Baltimore Md 21215 But ter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death tmmedi te cause (Final disease condition resulting in death) LIVER FAILIURE FOUR DAYS Due to (or as a consequence of): ONE YEAR LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): SIXTEEN HEPATITIS C Due to (or es a consequence of): YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown DIABETES MELLITUS 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was an eutopsy performed? BEHCETS SYNDROME HYPERTENSION 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner?

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Funeral

Director

7 is merked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer deeth v Department of Heelth end Mental Hygiene. Important: if frem 27 is marked other than "natural". v learning or other traumatic even.

the Marylend Works

with

aftar deeth. 24 hours a Hospital 24 hours a To the F within 2

State

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

APR 23 1999

investigation

Archane K Shlandher,

6 Could not be determined



1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number RES 000 29d. Dete signed (Month, Day, Year)

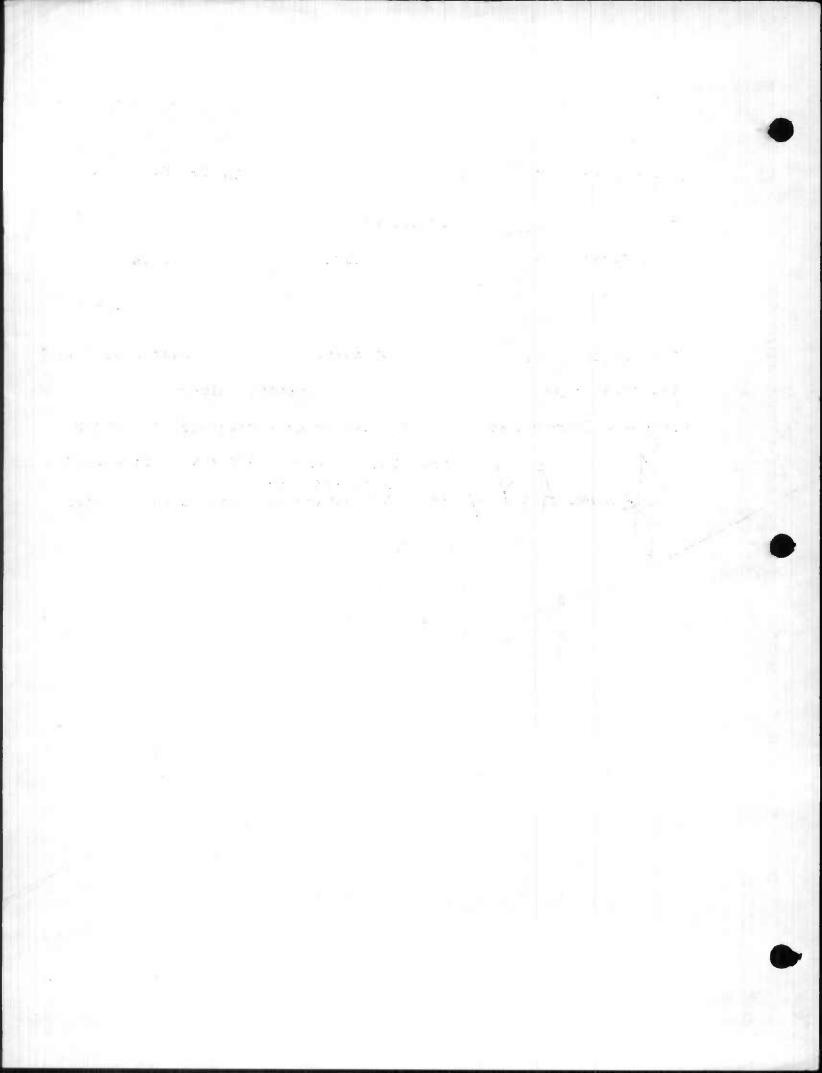
APRIL

1999

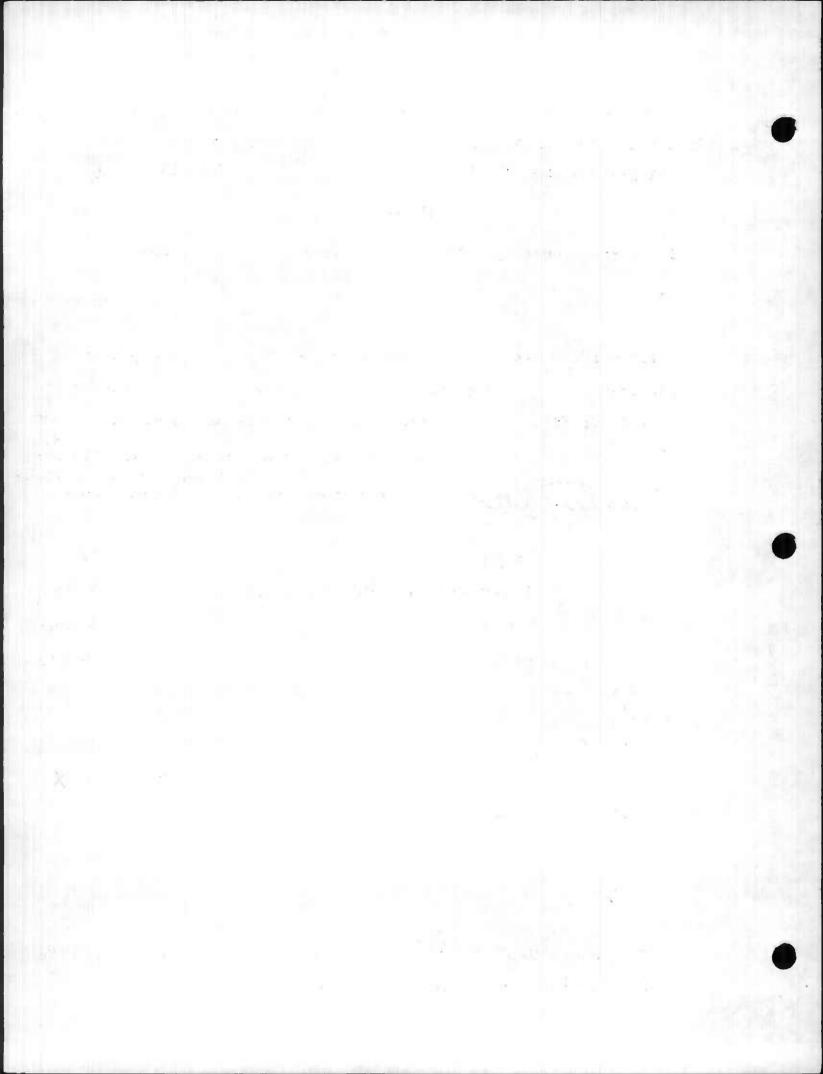
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ARCHANA K SHYANSUNDER, 3001 SOUTH HANOVER

STREET, BALTIMORE, HARYLAND

Registrar

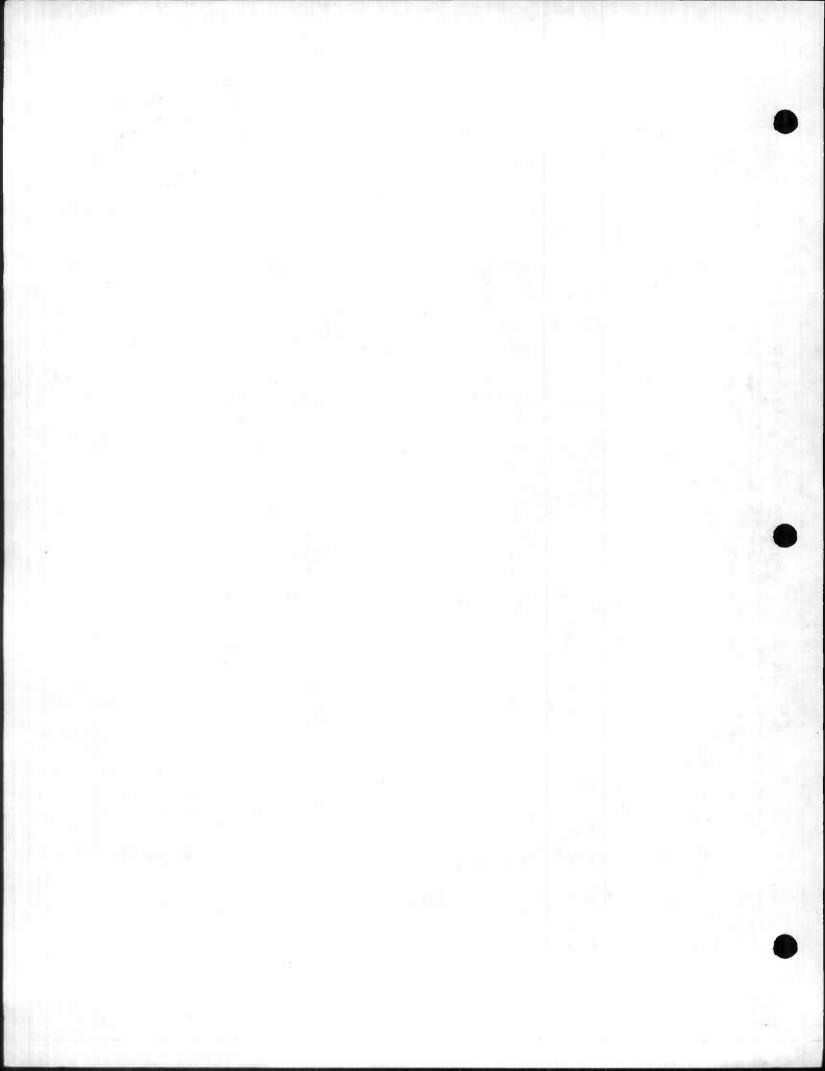


| ian | | ame (First, Midd | dia. I asti | | | | rtificate | 0, 1 | Juan | | 2. Date of Deat | eg. No. | | 3. Time of Death |
|--|--|--|--|--|---|--|--|--------------------------|--|-----------------------|--|--|---|--|
| cal | Tony | | D | | | Pa | rker | _ | | | ADVI | Day 21 | 999 | 12:2001 |
| ner | 4a Facility Nam | | on, give stre | eet and numb | ber) | | | 4 | b. City, Tow | n, or Loc | cation of Death | 4c. County | _ | |
| | THE JO: 5. Social Securit | HNS HOP | KINS I | - | and the second | last birthday) | If Under 1 | | BALTIM | | CITY 8. Date of Birth | | NA 9 Births | place (State or Fore |
| | | 5-4073 | | 2 k F | 33 | Yrs. | Months | Deys | Hours | Min. | 8. Date of Birth Month, Day 07-02 | -65 | Cour M | ntry) |
| | Usuai Residence 10a. State | of Decedent 10b. Count | у | | 10c. Ci | ty, Town or Lo | ocation | | | | | | 1 | Od. fnside City Limi |
| י פווסים: פווסים: | MD | I | NA | | В | altim | ore | | | | | | | XX Yes 2□N |
| | 10e. Street and | | | | | _ | 10f. Zip C | | 20 | | 1 | 0g. Citizen of | What Cour | ntry? |
| | 31 / No | orth A | | Was Deced | | | | 120 | | n? (Spec | city Yes or No- | USA 14. Bac | ce - Americ | can indien, |
| | 1 Never M | arried 2☐ Mai d 4☐Divorce | rried | Armed Force 1 Yes 2 If Yes, Give Year or Date | es? X No | | if Yes, specif | | Specify: | Puerto F | cify Yes or No- Rican, etc.) | | ck, White, | |
| | | 15. Decede | nt's Educat | tion | 00. | 16a. Dece | dent's Usuai | Occup | ation | ad complete | | 16b. Kind of B | | |
| | | pecify only higher econdary (0-12) | | College (1-4 | 4or 5+) | life. | kind of work DO NOT use | retirea | during most (| or workin | ig | | | |
| | 12th 17. Father's Nan | Grade ne (First, Middle | | AV | | Ne | Never-worked 18. Mother's Nan | | | | | Unemp | - | ed |
| | Alpho | nso | | Н | aggin | s | | | L | avo | ne | | Par | ker |
| | 11000 | Name/Relation | | Print) | | | | | | | Route Number | | | |
| 20 | Martha 20a. Method of I | | ffin | | 20b. I | Place of Dispo | sition (Name | e of | | enu | e Balt | | | 21206 own, Siale M D |
| | t Burlat | 2 Cremation on 5 Other (S | | novai from St | | ceme <i>tery, cr</i> e lings | | | | m . | 04-26- | | | llstown |
| | 21. Signature of | | - | 1 | | | 2. Name and | | | | altimo | re, M | aryl | and 212 |
| | > 00 | hilo | 2N) | Tra | / | W | M.C. | Ma | rch F | H 1 | 101 E. | Nort | h Av | enue |
| | Immediate Caus | | | | cn line. | | | | | | | | i | interval Between Onset and Death |
| | disease or cond resulting in deat | lition (h) | θ | Seps | | or as a conse | quence of): | | | | | | | 12 hour |
| . Intracranial hemorrhage | | | | | | | | | | ge | | | | 12 hours |
| | resulting in deat | (h) | | , | Due to (| | her | ион | rha | ge | | | | 12 hours |
| | Sequentially list if any, leading the cause. Enter Ucause (Disease that Initiated eresulting in deat | conditions, o immediate nderlying on this series | | , | Due to (CVA) Due to (| rial | Nev | MOI | rha | ge | | | | 12 hours 4 days |
| | Sequentially list if any, leading to cause. Enter Ur Cause (Disease that Initiated eve | conditions, o immediate nderlying on this series | 6. V | , | Due to (| or as a consecutive or a consecutive or as a consecutive or as a consecutive or as a consecutive or as a consecutive or as a consecutive or as a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consecutive or a consec | Nev | MOI | rha | ge | | | | 12 hours 4 days 5 years 48 hours |
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| medical certification: 10 be completed by PhysiciaryMedical Examiner | resulting in deal Sequentially list if any, leading to cause. Enter U. Cause (Disease that initiated everesulting in deal Part II. Other signature of the caus | conditions, o immediate nderlying or injury ints h) Last inferred to medical invest of Could determine the condition of the could determine the condition of the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could determine the could be considered as a could be consid | d. Idons contributed at Idons contributed at Idons at Ido | pital: 12 Inp. 28a. Date of (Month.) 28e. Place o building ien: To the bas and manne | Due to (CA) Due to (CA) Due to (CA) Due to (CA) The patient 2 Injury Day Year) If Injury - At hard, etc. (Special est of my known is stated. | or as a consecutive of the conse | nt 3 DOA f 28 meet, factory, h occurred at vestigation, in | use giv | 26. Piace er: 4 Num yat k? Yes 2 N | of Death sing Hom 2 o | 24a. Was a perform 1 Ye (Check only on the 5 Reside 28d. Describe he can be called a can be called at the time, do at the time, do | n autopsy med? es 2 No es 2 N | 3 Pro 24b. Washington and confidence (Special red) ber or Run enner as a and due to | Haday. 5 year: 48 hour o the cause of deal bably 4 unknow for a autopsy finding railable prior to mapletion of cause death? Yes 2 No No No No Ty) |



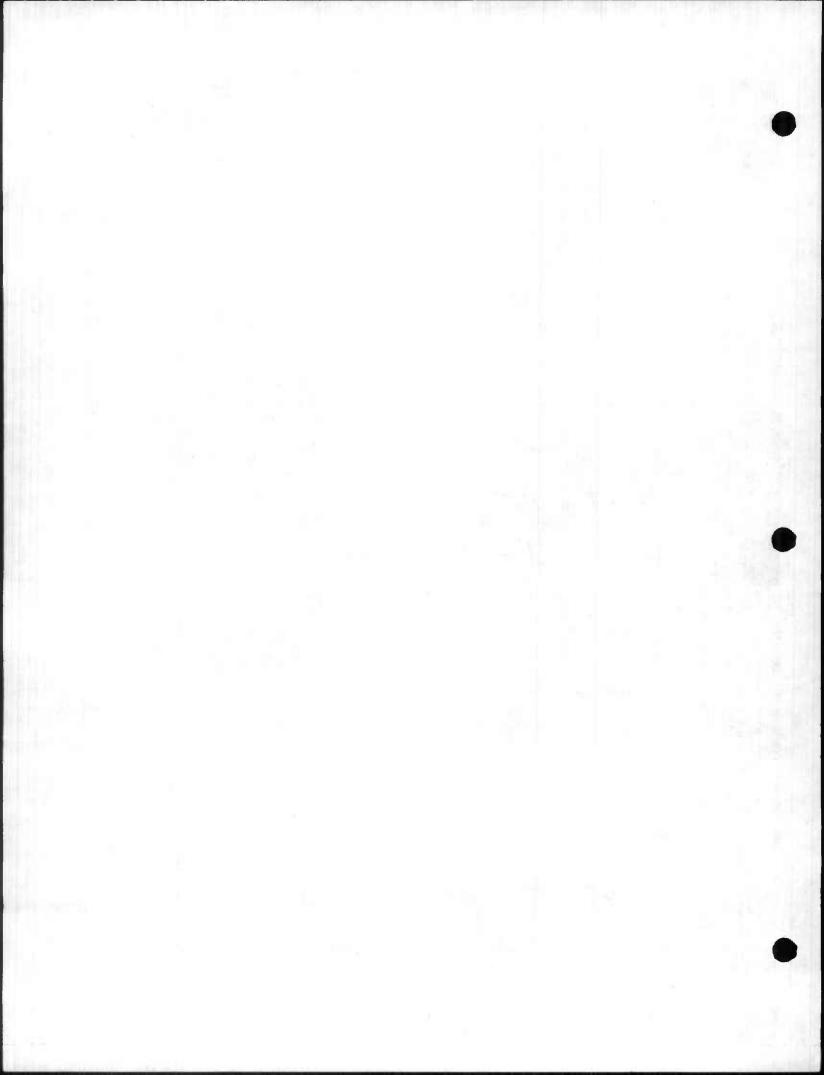
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

| | 1. Decedent's Nan | me (First, Middle, | Last) | | Cer | tificate of | Dealli | 2. Dete of Dea | | | 3. Time of Death |
|---------------------|--|--|---------------------------------------|--|--|---|---|---|---------------------------------------|------------------------|---|
| ysician Medical | Mar | | | Pink | ney | | | April | . 19, | Year 99 | 6:16am |
| aminer | 4a Facility Name | | give street end n Road Ap | | | | 4b. City, Town, or L Baltimo | | | I Deeth | |
| eral ctor | 5. Social Security | -9242 | 6. Sex 1 □ M 2 ☐ F | 7. Age (In yrs. 68 | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Day 02-25 | -31 | | ce (Stete or Forei |
| rector | Uaual Residence of 10a. State | 10b. County | | | ity, Town or Loc | | | | | 100 | 1. Inside City Limit |
| octor | MD | | IA | В | altimo | | | | | | XXYes 2□N |
| al Dir | 10e. Street and No. 2600 H | Round R | load | | | 10f. Zip Code 21225 | 5 | | 10g. Citizen of Wi USA | nat Country | y? |
| by Funeral Director | | ried 2☐ Marrie | Armed I | XIXNo Give | | Ves Decedent of H Yes, specify Cub ☐ Yes 2 ☑ No | dispanic Origin? (Sp an, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | | American White, etc | c. |
| pted | | 15. Decedent's | | | 16a. Deced | ent's Usual Occup | pation during most of world) | kina | 16b. Kind of Bus | | |
| Completed | Elementary/Sec | ondary (0-12) | T | (1-4or 5+) | | bled | d) | | unempl | oyed | E |
| 8 | 17. Father's Neme | | | ke | | | 18. Mother's Nam Celest | | Meiden Sumeme | | liams |
| To | 19a. Informent's N | | | N.S | 19b. Mailin | a Address (Street | and Number or Ru | | or, City or Town, S | | |
| | Madel: | | nkney | | | | shire L | | | | |
| | | | B □Removal from | n State M | Place of Dispos cemetery crem L. Z10 | sition (Name of eetory or other pla n Cemet | ery 04 | Dete -23-99 | Lanso | | |
| 9500 | 21. Signeture of F | unerel Service Li | censee Elm | onds | | Name and Addres | ess of Facility Ba | | e, Mary | - | |
| | 23a. Pert1. Enter shock, or he | the disease, dr c ert leilure. List o | omplications that nly one cause on | t caused the dea each line. | th. Do not ente | r the mode of dyi | ng, such as cerdiac | or respiratory er | rest, | 10 | Approximate ntarvel Between Onset and Death |
| an al | Immediete Cause disease or conditi | (Finel | P | ANCRE | ASIC | CANCE | ER | | | 2 | House |
| er | resulting in death) | | at | , | or as a consequ | uence of): | | | | | |
| Examiner | Convention Notice of | and division | b | Due to / | or as a consequ | sease all: | | | | 1 | |
| I Exe | Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated eventiles.) | mmediate lertying | C | 000.00(| 0, 20 2 00,1204 | | | | | | |
| Medical | that initiated even resulting in death) | ts Last | d. | Due to (| or as a consequ | ence of): | | | | | |
| clan | | tel a diab | | | | | = | L set Divis | | j | |
| by Physician/M | Pert II. Other signi | meant condition | s contributing to | death but not re: | suiting in the un | derlying ceuse gi | ven in Pert I. | | obacco use cont Yea 2. No | | ne causa or oe bly 4 □ Unk |
| Completed by Physic | | | | | | | 133 | 24a. Wes perfo | an autopsy med? | evail | a autopsy findin lable prior to pletion of cause sath? |
| Com | | | | | | | | 101 | res 201No | 10 | Yes 20 No |
| Be | 25. Wes case rele examiner? | | Hospitel: | 710000000000000000000000000000000000000 | 1500 | Ott | 26. Place of Dea | | | | |
| itlon: To | 1 Yes 2/2 27. Manner of Dea 1. Netural 2 Accident | | 28a. Date (Mo | Inpatient 2 C e of Injury onth, Day Year) | 28b. Time of Injury | 28c. Inju | 4 LI Nursing H | | dence 6 □Other | | |
| Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could no determin | 209. FIB | ce of Injury - At h ding, etc. (Speci | nome, lerm, stre fy) | et, lectory, office | | 28f. Location (S City or Tox | Street and Numbe m, State) | r or Rural i | Route Number, |
| edical C | 29a. Cartifier (Check only one) | 12 Certifying 2 Medical Ex | caminer: On the | ne best of my kno basis of examina unner steted. | owledge, death ation and/or inv | occurred at the tile estigation, in my o | me, date end place, ppinion, death occur | , and due to the cred at the time, | cause(s) and men date and place, a | ner as staind due to t | ted. he cause(s) |
| Medical Certifica | 29b. Signeture and | tille of certifier | | | | 29c. Licens | _ | | 29d. Date signed | (Month, Di | ey, Year) |
| | EST | Zeo W | us | | | 0.0 | 893 | | April Zi | D''C | 1997 |
| | 30. Name and add | | | | m 23a) (Type, F | | NE BYW | REENE | EL CEN | NER | |
| | CLAREN | CE SAR | KEDEE - | Aboro | | 200 | | Wh 213 | 201 | | |



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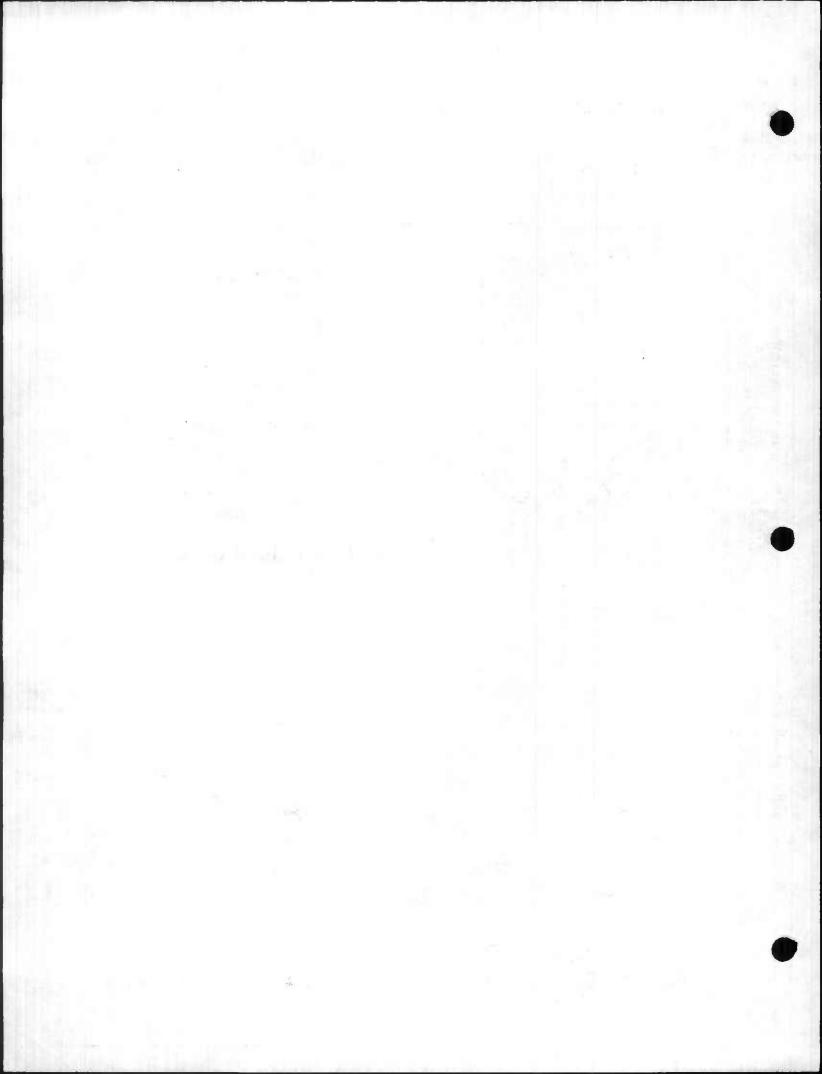
| or Description of the state of | (Specify only his Elementery/Secondery (0-1 7. Father's Neme (First, Mid John Baldwin | aution, give since a colls of the colls of t | Nursing 7. / M 2 X 7. / treet 2. Was Deceder Armed Forcas 1 Yes 6 Give Yeer or Detas ation | Home Age (In yrs. I. 69 10c. City B | Yrs. 7, Town or Localtimo | 101. Zip Code 21216 | 4b. City, Town, or I Baltimore If Under 24 Hrs. Hours Min. | 8. Dete of Bird (Month, Da Oct. 1 | 9, 1999 4c. County o n/a , Year) 5, 1929 | f Death Death By Birthplace Country) NC 10d. In | Z:15p.r (Stele or Fon |
|---|---|--|--|--|--|---|--|---|---|---|------------------------|
| 5.: 2 Use 10 M 10 11 11. | Irvington Kr Social Security Number 241-44-9287 suel Residence of Deceden 0a. Stete 10b. Con Md. 0e. Street and Number 1723 N. Benta 1. Maritel Status 1 Never Merried 223 3 Widowed 4 Divor 15. Dece (Specify only hi Elementery/Secondery (0-1) 7. Father's Neme (First, Mid John Baldwin | 6. Sex 10 tunty n/a lou St. Married ced dent's Educighest grade | Nursing 7. / M 2 X 7. / treet 2. Was Deceder Armed Forcas 1 Yes 6 Give Yeer or Detas ation | Home Age (In yrs. I. 69 10c. City B | Yrs. 7, Town or Localtimo | Months Days cation DICE 101. Zip Code 21216 | Baltimore | 8. Dete of Bird (Month, Da Oct. 1 | n/a v, Year) 5, 1929 | 9. Birthplace Country) NC | nside City Lin |
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| 100 1 1 11. | 1. Maritel Status 1. Maritel Status 1. Never Merried 2/3/3 Widowed 4 Divor 15. Dece (Specify only hi Elementery/Secondery (0-1) 7. Father's Neme (First, Mid | Married ced dent's Educations of grade | 2. Was Deceder Armed Forcas 1 Yas 2 5 If Yes, Give Yeer or Detas | nt Ever in U,s | S. 13. V | 10f. Zip Code 21216 | | | 10g. Citizen of Wi | | MV |
| 17. J | 1 Never Merried 2 Never Merried 3 Never Merried 4 Divor 15. Dece (Specify only his Elementery/Secondery (0-17. Father's Neme (First, Mid John Baldwin | Married rced dent's Educi ghest grade | Armed Forcas 1 Yas 2 F If Yes, Give Yeer or Detas | \$? ! \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | S. 13. V | Man Decadest of I | | | 10g. Citizen of What Country? USA | | |
| J | (Specify only his Elementery/Secondery (0-1 7. Father's Neme (First, Mid John Baldwin | ghest grade | ation | | Armed Forcas? If Yes, ap | | | pecify Yas or No Rican, etc.) | 14. Race - American Indian, Bleck, White, etc. Specify: Black | | |
| J | John Baldwin | - 4 | ation completed) College (1-4or 5+) ation 16a. Decedent's Usuel Or (Give kind of work de life. DO NOT use re | | | kind of work done DO NOT use retire | one during most of working stired) | | 16b. Kind of Business/Industry Agency | | |
| | | 17. Father's Neme (First, Middle, Last) 18. Mother | | | | | | me (First, Middle, Meiden Surneme) e Dudley | | | |
| 19 | 9e. Informant's Neme/Relat Hixie Lee Pil | 19e. Informant's Neme/Relationship (Type, Print) Husband 19b. Meiling Address (Street end Number of | | | | | | ural Route Number, City or Town, State, Zip Code) et Baltimore, Md. 21216 | | | |
| - | 20e. Method of Disposition 1 | | | | | | | Date | 20c. Location - C | ity or Town, S | Stete |
| 21 | 21. Signatura of Funerel Service Licensae 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 2121 | | | | | | | | | | ic. |
| Se if a ca ca the re: | Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | | |
| Pe | and II. Other plantifles at a se | italiano contribution to death but accommission to | | | | | | anh pid | 23b. Did tobacco uss contribute to the cause of c | | |
| | Pert II. Other significant conditions contributing to death but not resul | | | | uning in the underlying cause given in rent. | | | | 1 Yes 2 No 3 Probably 4 Uni | | |
| | | | | | | | | an eutopsy rmed? | | la prior to | |
| | | | | /60C | | | | 10 | ras 2 No | 1 □ Ye | s 2 No |
| 25. Was case referred to medical exeminer? 1 Yes 2 No | | | | | | | | | (Cassitu) | | |
| 27. | 7. Manner of Death Death 5 Pe 2 Accident inv | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury et Work? 1 \(\text{Yes} 2 \) No | | | | | | edo Nembas | | |
| 20 | 4 Homicide del | ermined | 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | | | | | |
| 2 | (Check only 2 Medi | cal Examine | er: On the besis and manner: | of examineti | ion end/or Inv | restigetion, in my | me, date end place opinion, deeth occu | red et the time, | date end plece, a | nd due to the | ceuse(s) |
| | 29b. Signeture end title of certifier D47405 | | | | | | | 29d. Data signed 4/2/19 | (Month, Day, | Year) | |
| 1 | D. Name and address of period. A. A. A. T. 1. Date filed (Month, Day, You | 461 | 821 | | 23a) (Type, 1 | | t Balti | nou | MD 21 | 201 | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | Certific | cate of Death | Reg. No. | 13378 | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|--|--|
| Dhusisian | Decedent's Nama (First, Middle, Last) | 2 | 2. Data of Death Month Day Year | 3. Time of Death | | | | | | | |
| Physician /Medical Examiner | Helen Aphrodite Mooseles Phipps 4a Facility Nama (If not institution, give street and number) | 4b. City, Town, or Loca | April 19 1999 | 6:00 am | | | | | | | |
| Examiner | Genesis Eldercare - Spa Creek | | Anne Arundel | | | | | | | | |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If I | onths Days Hours Min. | Deta of Birth 9. Birth (Month, Day, Year) | tholece (State or Foreign buntry) | | | | | | | |
| Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland begannent of Health and Mentel Hygiend Hysiens after deeth with the Meryland popularitif it flam 21% or 18 marked other than "natural", or terms 23% or 28% I ahow my injury or other traumatic event, as well as a factor must be notified as age. To Be Completed by Funeral Director | Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location | | | | | | | | | | |
| | | | 10d. Inside City Limits 1- Yes 2 □ No | | | | | | | | |
| | | Of. Zip Code | 10g Citizen of What Co | 10g. Citizen of What Country? | | | | | | | |
| | 135 Porter Drive | 21401 | USA | | | | | | | | |
| | 1 Nevar Marriad 2 X Married 1 ☐ Yas 2 Y No | Decedent of Hispanic Origin? (Specifs, specify Cuban, Mexican, Puerto Rid es 200 No Specify: | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) (Give kind | S Usual Occupation of work done during most of working | 16b. Kind of Business/ | 16b. Kind of Business/Industry | | | | | | | |
| | Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemake | IOT use retired) | Own Home | | | | | | | | |
| | 17. Fathar's Nama (First, Middle, Last) | 18. Mother's Name (I | First, Middle, Maiden Surname) | | | | | | | | |
| | John Theodore Mooseles | Helen Sea | elen Sears | | | | | | | | |
| | 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Ad | dress (Street and Number or Flural F | and Number or Flural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| | | rter Drive, Annap | colis, MD 21401 | | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator, Metro Cremat | ry or other place) | Data 20c. Location - City or 4/20 Baltimore, | | | | | | | | |
| Baltimo permit. Pagei Department of important: If i any injury or page. | 21. Signature of Foraret Service Licensee 22. Nama and Address of Facility Hardesty Funeral Home, P.A. | | | | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflieted Between Consert and Death Consert and D | | | | | | | | | | |
| Physician /Medical Examiner | 0 | and varale | | Onset and Death | | | | | | | |
| X 68760, certificate be executed ding physician and se as the bunel-trensit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of the consequence o | | | | | | | | | | |
| death cert death cert death cert death cert death cert death cert death | Part It. Other significant conditions contributing to death but not resulting in the underly | sing source plans in Plant I | 23b. Did tobecco use contribute to the cause of death? | | | | | | | | |
| executes, P.O. we require that the is been signed by the 2 should be detached by Physical | Fact it. Other arginiticant conditions contributing to death out not resulting in the univers | ying cause given in Part I. | 1 Ves 2 No 3 Probably 4 20 Naknown | | | | | | | | |
| | | | nerformert? | Were autopsy findings available prior to completion of cause of death? | | | | | | | |
| | | | 1 ☐ Yes 2 €No | 1 ☐ Yes 2 ☐ No | | | | | | | |
| of Vital Re Physician: The tall this certificate he rel director, page: To Be Com | 25. Was casa ratarred to medical axaminar? | 26. Place of Death (6 | Check only one) | | | | | | | | |
| of Vita Physicien: this certific rel director, | Hospital: | DOA Other: 4 Horsing Home | Nome 5 Residence 6 Other (Specify) | | | | | | | | |
| Division or to the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: | 27. Mannar of Death Natural 5 Panding (Month, Day Year) 28. Data of Injury (Month, Day Year) 28b. Tima of Injury M | Work? | 28d. Describe how injury occurred | | | | | | | | |
| | 3 Suicide 4 Homicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, fabuilding, atc. (Specify) | 28a. Place of injury - At home, farm, street, factory, office ∠of. L | | | | | | | | | |
| | 29a. Cartifiar (Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) | urred at the time, data and place, and pation, in my opinion, death occurred | d due to the cause(s) and manner as at the time, date and place, and due | s stated. to the cause(s) | | | | | | | |
| To the within To the common | 29b. Signature and title of certifier | 29d. Data signed (Mont | 29d. Data signed (Month, Day, Year) | | | | | | | | |
| ln . | 30-Name and addrass of person who completed causa of death (Item 23a) (Type, Print) | Drove Chest | e mud/619 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registrar's Signatura | -1- | | | | | | | | | |
| 1.05101141 | APR 23 1999 | Brakel | | | | | | | | | |

DHMH 16 Ray 6/95



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|---|---|
| State of Maryland / Department of Health and Mental Hygiene | 0 |
| a array a array continued of Double | 1 |

| DONALD C. F ITEMS: #23 | REI PA |
|-----------------------------------|-----------|
| Physician /Medical Examiner | 1. 4a |
| Funeral Director | 5. |
| Meryland and show dract at | 10 |

Direc Funeral p Completed 8

Peges 1 and 2 should be filed within 72 hours efter death with the nant of Health end Mehriel Hygiene.
rdt: if flem 27 ie marked other than 'naturel', or flems 23a or 28a may or other treumstic event, the Medes I Empirer man be not Department of Important: If any Injury or page.

Baltimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vital

Hospital

To the To the To the P

Physician /Medical Examiner

The lew requires that the death certificate be executed physician street ... signed by the e or Attending Physician: funeral director, this After deeth 24 hours efter deet Funeral Director: 3 filled in

NAULT RT 1, 27, 28A-F PER MEO G770 4-27-99 WR. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Donald C. Renault APRIL 21, 1999 0230 AM Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 9731 RED CLOVER COURT BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 12 M 20 F 217-80-0223 38 Nov 29, 1960 Baltimore, Md. sual Residence of Decedent ne State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💆 No Baltimore Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9731 Red Clover Court 21234 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Alfred E. Renault Annabelle Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md. Dennis C. Renault (Brother) 4601 Shamrock Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriaf 2 Ø Cremetion 3 ☐ Removal from State Hilltop Service Corp. 4/23/99 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) Knight Jy 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Milton J Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feiture. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE NARCOTIC INTOXICATION Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown Completed by 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 12 es 2□ No å 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) No 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation ound 2:24 1 Natural UNKNOWN 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 9731 RED CLOVER COUTY 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide FOUND AT HOME BALTIMORE COUNTY, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated.

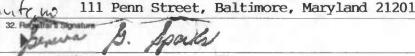
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) XX Medical Exami 29b. Signature affet title of certified 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

completely

31. Date filed (Month, Day, Year)

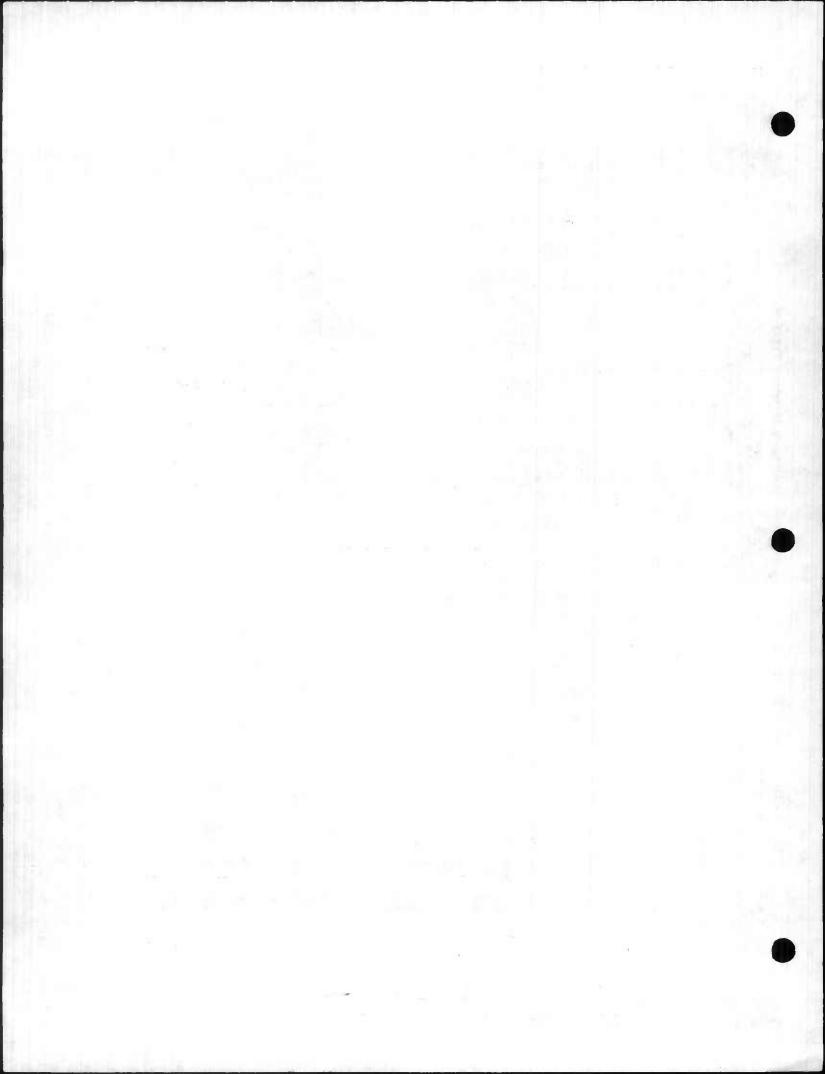
and address of person who



d cause of death (Item 23a) (Type, Print)

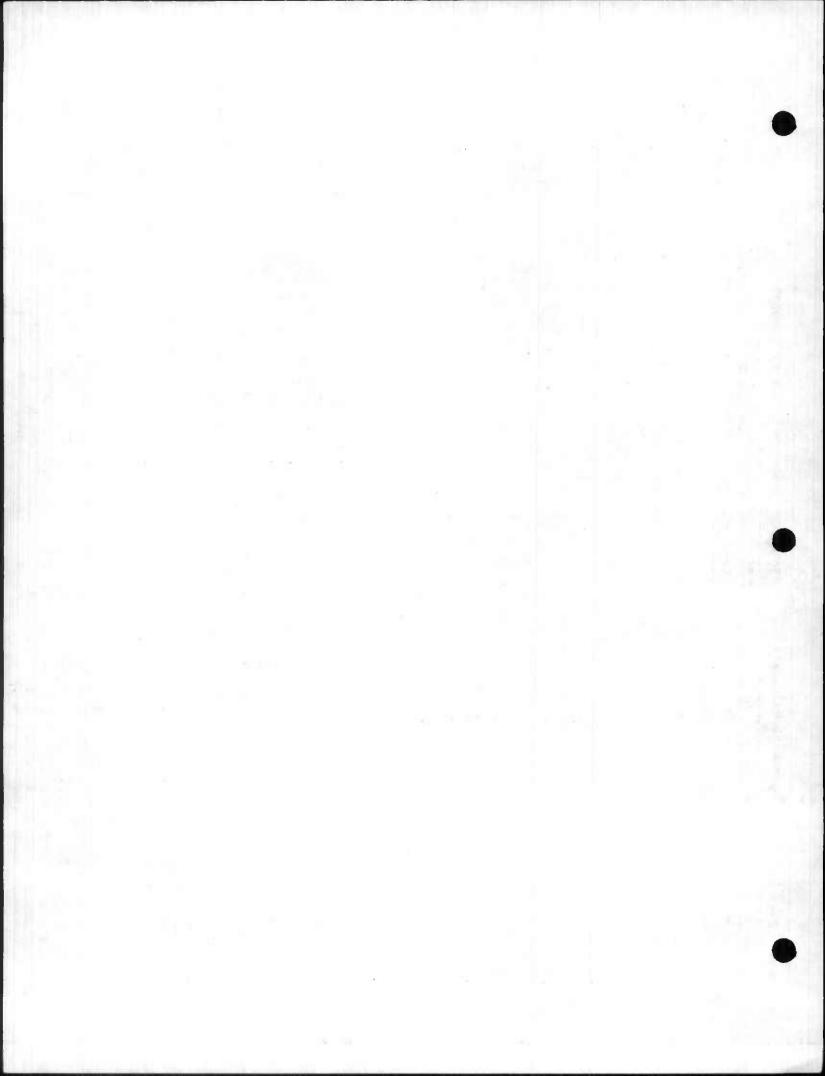
O.C.M.E

APRIL 21, 1999



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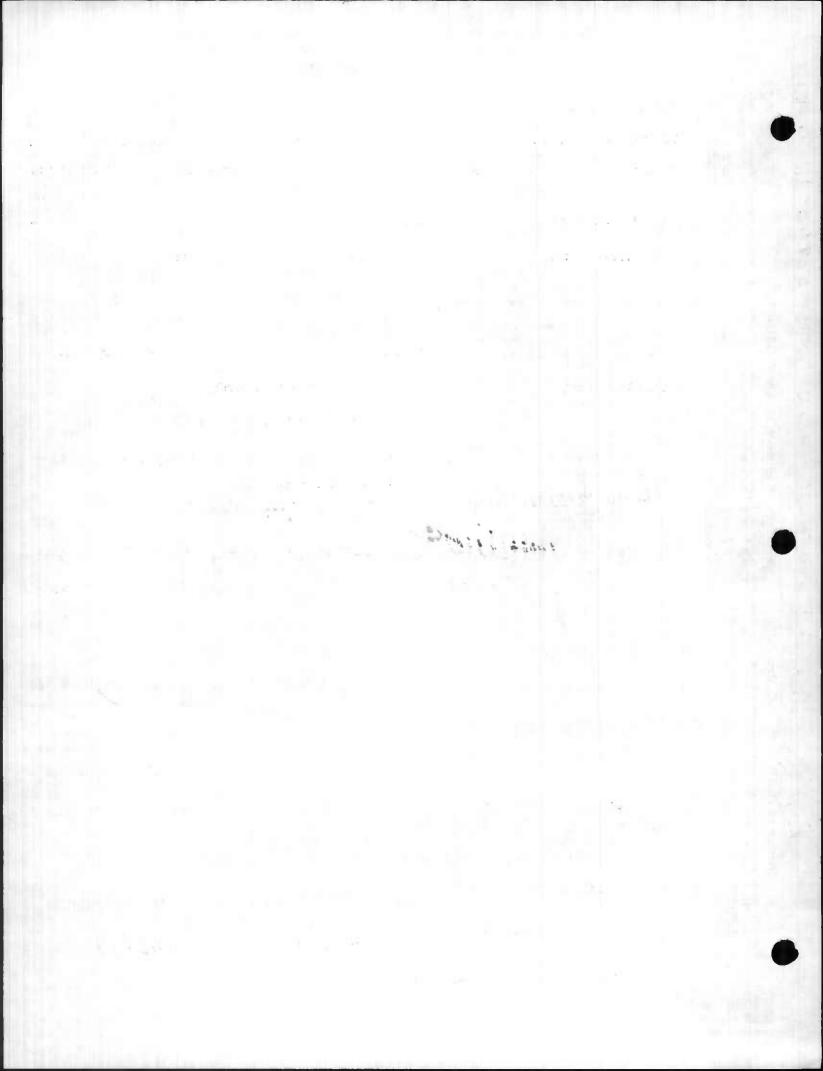
| | | | | ai yiai iC | Certifica | | | | Reg. No. | 9 13380 | |
|--------------------------------------|---|---|---------------------------|----------------------|---|---------------------------|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Neme ERIC 4a Facility Nema (If r. | | | | RICH | ALO: | 50 V 4b. City, Town, or | 2. Data of Domestin Month APC 1. Location of Dea | L 18 / | Year 1999 2:54 of Deeth | |
| uneral rector | 5. Social Security Nur 217-78- Usual Residence of D | 9164 X | THE OF LEE | 5 / 0 (In yrs. la | St birthday) If Un Yrs. Month | der 1 Year ns Days | | | ay, Year) | 9 Birthplaca (State or Ford Country) MD | |
| - | | Ob. County | | 10c. City, | Town or Location | ., | | | | 10d. Inside City Lim | |
| Funeral Director | MD NA Baltimore | | | | | | | | XX Yes 2□ | | |
| Director | 10e. Street and Numb | per | | | 10f. | Zip Code | | | 10g. Citizen of \ | What Country? | |
| | 1712 No | | d Street | | | 1213 | | | US | | |
| by Fur | 11. Merital Status 1 Nevar Merried **Therried 12. Wes Decedent E Armed Forces? 1 Nevar Merried **Therried 11 Yes 2 Yes No H Yes, Give Year or Dates: | | | | | cedent of I pecify Cub | dispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or N to Rican, etc.) | o- 14. Rac Bled | es - Amarican Indien, ck, White, etc. | |
| Ped | /Specify | 5. Decedent's Edu only highast gradi | cation | | 16a. Decedent's U | suel Occup | pation during most of un | rekina | 16b. Kind of B | usiness/Industry | |
| Completed | Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade NA | | | | Techn | | during most of wo d) | "NITY | ABacu | s Corp. | |
| To Be | 17. Father's Neme (Fi | | rrison | | | | 18. Mother's Ne Gracie | | Jenki | | |
| | 19e. Informent's Nem | e/Reletionship (Ty | rpe, Print) | | 19b. Mailing Addr | ess (Street | and Number or R | ural Route Numi | ber, City or Town, | State, Zip Code) 2121 | |
| | Terita 20a. Method of Dispos 1X Buriat 2 | sition | ardson Removal from State | COL | nce of Disposition (I metery, cremetory of | Vame of or other pla | ce) | Dete | 20c. Location - | Maryland City or Town, Stele | |
| | | Other (Specify) | | Kı | | | | | | dallstown,M | |
| Source Control | 21. Signature of Funerel Service Licensee 22. Nama and Address of Fecility Baltimore, Maryland WM.C. March FH 1101 E. North Ave | | | | | | | | | | |
| edical | Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La | itions, ediate ing iury | HEPAT | Due to (or e | CATIVE es a consequence NSUFF es a consequence o | BAK 01): 1 C 1 C | ucy. | I A | | 24 hours 20 A43 1 4 EAL 20 4 ES | |
| clan | | | | | | | | | | | |
| Phy | Part II. Other significa | | LL DIS | | | g cause gi | ven in Pert t. | | Nd tobacco use contribute to the cause of de ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unit | | |
| Completed by | | | | | | | | 24a. We | s an eutopsy ormed? | 24b. Were autopsy finding available prior to completion of cause of death? | |
| Co | | | | | | | | 10 | Yes 2 No No | 1 ☐ Yas 2 ☑ No | |
| B | 25. Wes case referred examiner? | L | fospital: | | | J OH | 26. Place of De | eth (Check only | one) | | |
| - T | 1 ☐ Yes 2 ☑ No 27. Manner of Death | , | 1 La Inpatier | | R/Outpatient 3 28b. Time of | DUA | 4 Li Nursing I | T | idence 6 Oth | | |
| Medical Certification: To Be Complet | 27. Manner of Death 1 \$\sqrt{Neturet}\$ \$ \sqrt{Pending}\$ investigation 3 \sqrt{Suicide} \$ 6 \sqrt{Could not be determined} \$ \text{Deterof Injury - At home, term, street, fectory, office} \$ \text{28a. Dete of Injury (Month, Day Year)} \text{28b. Time of Injury at Work?} \$ 1 \sqrt{Yes} 2 \sqrt{No} \$ \text{28c. Injury at Work?} \$ \text{1 \sqrt{Yes}} 2 \sqrt{No} \$ \text{28e. Place of Injury - At home, term, street, fectory, office} \$ \text{28e. Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} } \$ \text{28e. Place of Injury - At home, term, street, fectory, office} \$ \text{28e. Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} } \$ \text{28e. Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} } \$ \text{28e. Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} } \$ \text{28e. Time of Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} \$ \text{28e. Injury at Work?} \$ \text{1 \text{Norme, term, street, fectory, office} \$ \text{28e. Injury at Work?} \$ | | | | | | | 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Nu- City or Town, State) | | | |
| edical Ce | (Check only 2 | Certifying Phys | sician: To the best of | examinatio | ledge, death occurr on and/or investigat | ed et the ti | me, date end place | e, end due to the urred at the time | cause(s) and ma | anner es stated. and due to the cause(s) | |
| 2 | one) 29b. Signature and titl | e of certifier | and manner ste | ted. | | 29c. Licens | se number | 1 | 29d. Date signe | d (Month, Day, Year) | |
| | 150 | and 10 | plan | | | | -000 | | | 19, 1999 | |
| | | AK CAN WD | Johns Ho | pkins | Mospital. | Tuve | 110 ; 60 | o N. WOLFE | ST, BALT | timune, mo 2128 | |
| State | 31. Dete filed (Month, | IPR 23 10 | QQ 32. Registra | r's Signatu | re A. | door | (2) | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ADMIT 16, 1999 **Physician** 1645 Charles L. Ridgely /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Merch 9,1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2□F Months 217-26-7162 86 Yrs Baltimore, Maryland Director Usual Residence of Decedant the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 113 1 ☐ Yes 2 ☐ No Baltimore Maryland Baltimore County Directo 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? death with B03109 4340 Glermore Avenue 21206 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status hours efter 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WA Warehousenan Nationwide Paper Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guilford D. Ridgely Mary H. Deckwalz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Frey RR2 Box 92AA Frankford, Deleware 19945 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest V.A. Cem. April 22,1999 Owings Mills, Maryland 22. Name and Address of Facility Lassahn Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Chronic obstructive Examiner Examiner we under Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? been signed by t should be detach 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ils certificate has t director, page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Matural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durkis 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Registrar

1/2

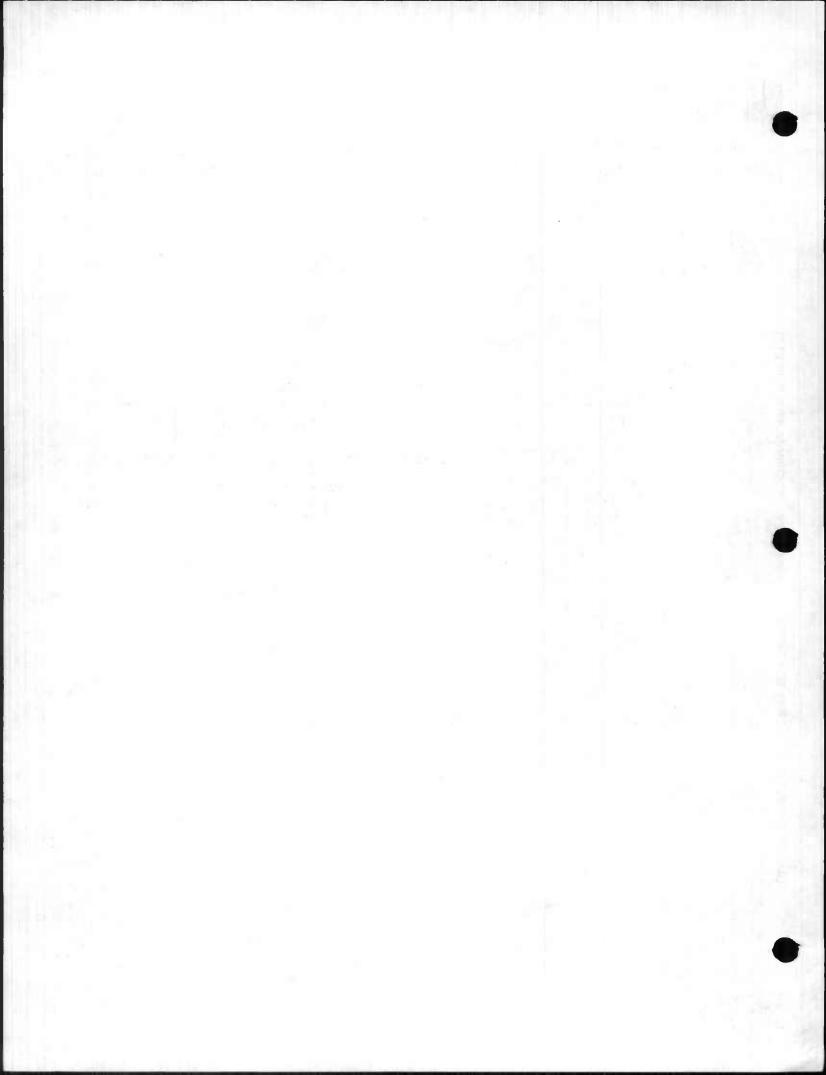
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** ROSEMARY MARGARET SPENCER 1999 APRIL 22 4:20 P.M. /Medical 4a Fscility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner **GLENDALE** 6822 BARNETT ROAD BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 K) F Director 212-05-2799 83 12/23/15 MARYLAND Usuat Residence of Decedent the Meryland I show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No MD GLENDALE 10e. Street and Number 10f. Zio Code 10a. Citizen of Whet Country? 늄 6822 BARNETT ROAD 21239 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11 Marital Status Bieck, Whita, etc. filed within 72 hours efter 1 Yas 2 No If Yes, Give Yaar or Dates: 1 Never Merried Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry lith and Mental Hygians. 27 Is marked other than "r r treumatic event, on Men Elementery/Secondary (0-12) College (1-4or 5+) 12th GRADE **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fill mant of Health and Mental Hant: If Item 27 la marked oth jury or other treumatic even Be ANNA FLOOD JAMES E. MEYERS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE E. SPENCER, SR. HUSBAND 6822 BARNETT ROAD BALTIMORE, MD 21239 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from Steta permit. Page Department of Important: If any Injury or page. 4 Donation 5 Othar (Specify) DULANEY VALLEY MEM. GAR. 4/26/99 COCKEYSVILLE, MD 21. Signature of Funerei Service Licenses 22 Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. The 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 ns that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory srrest, une on each line. 23a. Part 1 Enter the disease, or complications shock, or heart tailure. List only one countries Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificets be execu Box 68760 Physician/Medical the Due to (or as a consequence of): . USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records. 29 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2000 1 Yes 2016 certificate of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Praesidence 6 Other (Specify) 1 Yes 2 4 No edical Certification: To this funeral 28a. Dete of trijury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After Division 1 Netural 5 Pending investigation ne Hospital or Attending in 24 hours after death. he Funeral Director: Aftr pletaly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. Within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK 6-ELOS 801 LIGNOS TOWSON MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

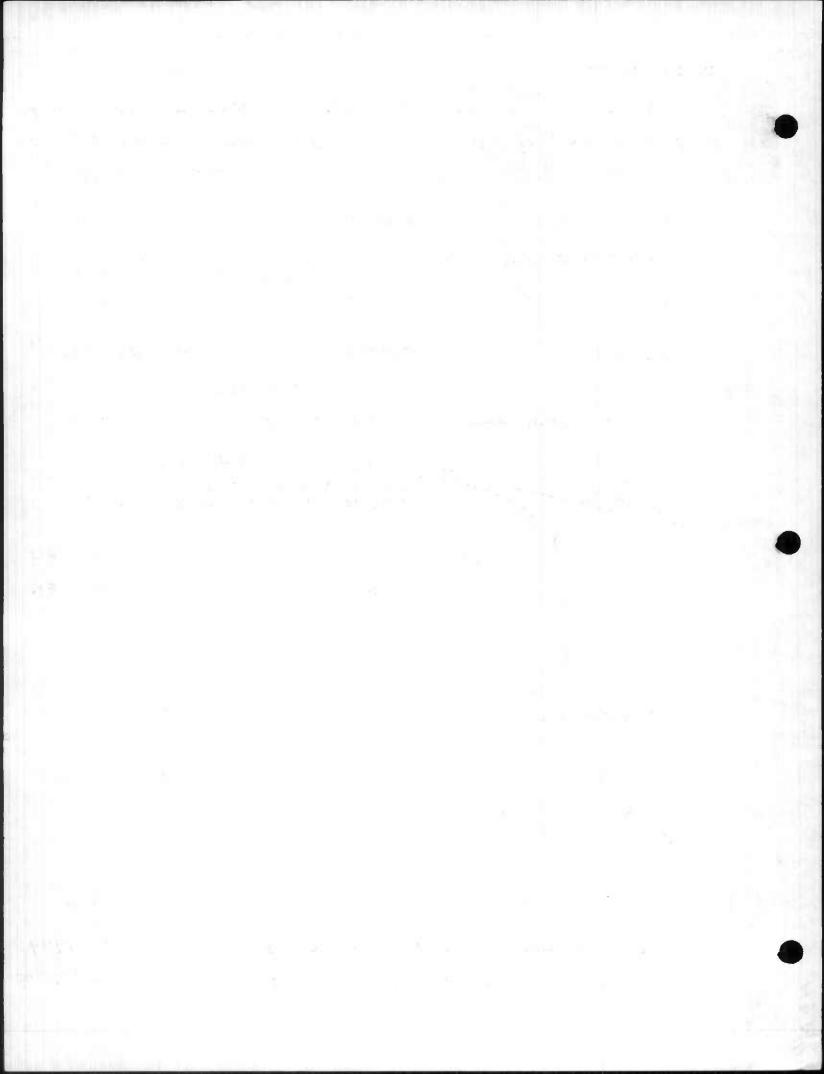
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| | State of Maryland / Department of Health and Mental Hygiene (| 1 |

State of Maryland / Department of Health and Mental Hygiene Item#19a perInf G771 5/4/99 EW Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month STEGMAIER JAMES APRIL 6.00pm 1999 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL GOOD SAMARITAN BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Director 215-24-7207 MARYLAND Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner nust be notified at Director 1 X Yes 2 □ No MD BALTIMORE CITY N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Нета 23а 6101 LOCH RAVEN BLVD. APT. 307 21239 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Health any no other trauments. 1 Never Married 2 Married 1 Yes 2 No tf Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 ☐ Divorcad WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) CUSTODIAN MAINTENANCE DEPT. 9th GRADE 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) CHRISTOPHER STEGMAIER EDNA BOLLINGER 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT BURKE Bro-in-law COUSIN 7872 ROLLING VIEW AVE. BALTIMORE, MD 21236 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 DBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4/23/99 BALTIMORE, MD PARKWOOD CEMETERY 21. Signature of Funeral Service Licenses THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 In Briff Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or haart failure. List only ona cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIC WESKS disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner 2 WEEKS PNEUMONIA that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): pue buriai Box 68760. physician Physician/Medical the Due to (or as e consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco uea contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown CIKRITOSIS signed I Records, λq 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s this certificate 1 ☐ Yes 2 No Vital or Attending Physician: Be 25. Was case rafarrad to medical examiner? 26. Place of Death (Check only ona) Hospital: 1□ Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA o 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? After Division 1 Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hour.
The Funeral Direction of the Funer Hospital 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and dua to tha causa(s) and manner as statad.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certific 29c. License number P12557 APRIL 20, ms 30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) LOCH RAVEN BLUD, BALTIMORE MD 21239-2995 RAPHAEL DODOO 5601 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

| | | | | | artment of rtificate of | | | Reg. No. | 99 ! | 3384 | |
|--|--------------------------|--|--|------------------------------------|--|--|--|---------------------------------------|-----------------------------------|---|--|
| Physic | ian | Decedent's Neme (First, Middle, L | | | | | 2. Dete of D Month | Deeth Dey | Yeer | 3. Tima of Death | |
| _ /Medi | | Ronald M. Squirre | | | | | APRIL | 19 | 1999 | 0647AM | |
| Exami | ner | 4a. Facility Name (If not institution, g St. Agnes Hospit | ALL COLORS OF THE SECTION OF THE SEC | | | 4b. City, Town, or Baltimor | | 4c. Coun | ty of Deeth | | |
| Funeral | | | | rs. last birthday | If Undar 1 Yaar Months Deys | | | lirth | 9. Birthpla | ca (Stete or Foreign | |
| Director | | 217–82–1375 Usuel Residence of Decedent | X□M 2□F 29 | Yrs. | | | Lep 18 | , 1970 | Marylar | id · | |
| yand w | | 10a. Stete 10b. County | 10c. (| City, Town or L | ocation | | | | 100 | I. Inside City Limits | |
| r 28a-f show | tor | MD | Ba1 | timore | | | | | | 1 Yes 2 □ No | |
| within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-1 ahow he Madreil Evanines must be notified at | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizan of | Whet Country | γ? | |
| th wil | al D | 3400 Benson Ave | | | 21227 | | | United | States | 3 | |
| ter dea | ner | 11. Maritel Status | 12. Was Decedent Ever in Armed Forces? | U,S. 13. | Was Decedent of It Yes, specify Cul | Hispanic Origin? | (Specify Yas or Narto Rican, etc.) | lo- 14. Re | ce - Americer | | |
| or h | | Naver Married 2 Married | 1 ☐ Yes 2⁴ No If Yas, Give | | 1□Yes ¾ No | | | | Black | | |
| 72 hours "natural", | d by | 3 Widowed 4 Divorced | Yeer or Detes: | 10. 5 | | | | | | | |
| in 72 "nal | Siete | 15. Decedent's I (Specify only highest g | rade completed) | 16a. Dece (Give | dent's Usual Occu kind of work done DO NOT use retin | pation during most of weed) | orking | 16b. Kind of I | Business/Indu | stry | |
| 77 75 6 | Be Completed | Elementery/Secondery (0-12) N/A | College (1-4or 5+) | N/A | | , | | | | | |
| e filed other | Se C | 17. Fether's Name (First, Middle, Las | it) | | | 18. Mother's N | eme (First, Middl | le, Melden Sume | me) | | |
| should be ind Mentel I | ToE | UNKNOWN | | | | Alice So | uirrel | | | | |
| | ľ | 19e. Informant's Name/Reletionship | | | ng Address (Stree | | | | | ode) | |
| of Health item 27 l | | Kathy Kurran-Per | | | Pot Spri | ng Rd I | 'imonium | | | | |
| Pages 1 nent of H smt: If iten ury or oth | | 20e. Method of Disposition 1 Burial 2 Tremetion 3 4 Donation 5 Other (Special Control of the Co | □Removel from State | cemetery, cre | osition (Neme of matory or other pla int Crema | tory | Dete 4-23-99 | | -City or Town | | |
| pemit. Pages 1 ar Department of Hea Important: If item 2 any Injury or other once. | | 22. Nama and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 2128 | | | | | | | | | |
| Physician /Medical Examiner | | 23a. Pert1. Enter the disaasa, or conshock, or heert tailure. List only immediate Ceuse (Finel disaesa or condition resulting in death) | · Aspac | chion | Pre | Ing, such as cardi | | arrast, | li li | opproximata hterval Between Inset and Deeth | |
| thet the death certificete be executed ed by the attending physician and detached for use as the bunial-transit | in/Medical Examiner | edicai | Sequentially list conditions, if eny, leeding to immediate couse. Enter Underlying Ceuse (Disease or Injury thet intitled events resulting in deeth) Last | b. Due to | (or es e consec | quence of): | | | | | |
| the at | /sici | Pert II. Other significent conditions | contributing to death but not re | esulting in the u | nderlying ceuse g | ivan in Part I. | 23b. Die | d tobacco use c | ontribute to t | he cause of death? | |
| thet the | Ph | Cerebral Pa | ilsa | Suste. | mie L | vars. | 10 | Yes 2□No | 3 Probe | bly 4 Unknow | |
| 2 50 | Completed by Physician/M | Myositis | SEIZU | e d | mie C | | 24e. We | es an autopsy formed? | aveile | autopsy tindings able prior to pletion of cause eth? | |
| 0 - 0 | Eo | | | | | | 1 🗆 | Yes 20 No | 10 | res 2□ No | |
| ysician: The second sec | Bec | 25. Wes case referred to medical exeminer? | | | | 26. Plece of D | eath (Check only | ona) | | | |
| 2 00 | To | 1 ☐ Yes 2 No | Hospitel: 1 Inpatient 2 | ER/Outpetier | nt 3 DOA | her: 4□ Nursing | Home 5 ☐ Res | sidence 6 🗆 Ot | her (Specify) | | |
| l or Attending Phetier death. Director: After the in by the funere | | 27. Manner of Deeth 1 Neturel 5 ☐ Pending | 28e. Dete of Injury (Month, Dey Year) | 28b. Time o Injury | f 28c. Inju Wo | iry et ork? | 28d. Describe | how Injury occu | rred | | |
| leath. tor: A the fu | cati | 2 Accident Investigation 3 Suicide 8 Could not | | | M 1 | Yas 2□No | | | | | |
| effer of Direct | Certification: | 4 Homicide determined | | home, ferm, str cify) | reet, fectory, office | | 28f. Location City or To | (Street end Num own, Stete) | ber or Rural F | Route Number, | |
| To the Hospital or Attending Ph within 24 hours efter death To the Funeral Director: After thi completely filled in by the funerel | edicai (| 29a. Certifier (Check only one) Certifying P | hysician: To the best of my kr miner: On the basis of examir end manner stated. | nowledge, deat netion end/or In | n occurred et the ti vestigation, in my | ime, date end plac opinion, death occ | ce, end due to the curred et the time | e ceuse(s) and m e, date end plece | nenner es stet , end due to th | ed. ne ceuse(s) | |
| To the To the Comp | Me | 29b. Signature and title of certifier | Emergency Al | Ty Si cia. | 29c. Licen | se number | 3 | 29d. Date sign | ed (Month, De | y, Year) | |
| | | | | | | | | | | | |

State Registrar

APR 2 3 199

32. Registrar's Signeture

B. Sparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month 4a. Fecility Name (If not institution, give street and number) 1001 /Medical 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Center Randallstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠ M 2□ F Days Yrs Director 214-18-0899 74 Dec. 15, 1924 Maryland Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Woodlawn 10e. Streef end Number 10f. Zip Code 10g, Citizen of What Country? ò items 23a 21207 Funeral 3439 Liberty Gardens Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours efter ond Mental Hygiene.

marked other than "natural", or ite 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Nerried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐xNo Specify: by Specify: 3 Widowed 4 Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 -0-General Contractor Self Employeed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be f nent of Heaith end Mental I int: If Item 27 Is marked of Howard Singleton Blanche. E.__ Widerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra 723 Milford Mill Road Pikesville, MD Mrs. Bridget Singleton 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 4/26/99 Sykesville, MD Lake View Mem. Park 21. Signature of Funerai Servica Licansee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD shock, or heart failure. List only one cause on each line. 21133 Approximete Interval Between **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medicai the Due to (or as a consequenca of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b feel Cahur Records. þ Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior fo completion of cause of death? page 2 1 ☐ Yes 2 ☐ No Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetlent 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To of this funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? s efter death.
I Director: After t 28d. Describe how Injury occurred 5 Pending investigation Division 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital within 24 hours of To the Funeral L edicai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely ş 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Walthurg 32. Registrar's Signature

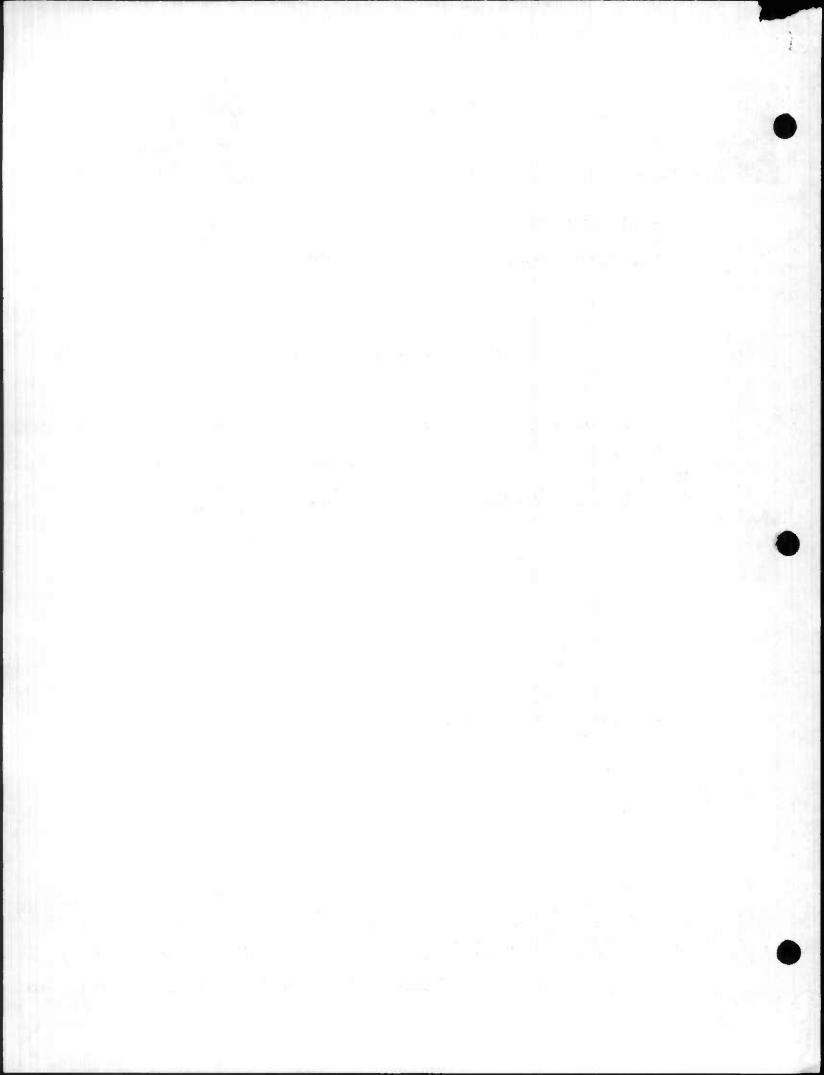
Hog, tel

Randalle Town,

AHCO

DHMH 16 Ray 6/95

State Registrar 31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year 1999 Daniel Α. Santoni, Jr. April 21 11:30PM 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 7 Harbel Ct. Apt. Tl Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Days 1 ₽ M 2 □ F 215-52-0956 55 Yrs. March 6 1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inalde City Limits 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Harbel Ct. Apt. Tl 21236 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Juvenile Counselor +6 Supervisor 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Ann Welsh Daniel A. Santoni, Sr. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Thurkill Ct. Cockeysville, MD. 21030 Mr. Timothy W. Santoni/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State Dulaney Valley Mem, Gdns. 4-28-99 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD. 21. Signeture of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21204 ons that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease or con shock, or heart failure. List only Immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequence of): 87 Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): U Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury at Work?

/Medical **Examiner** pue buriel-trar certificate be exec the 9

Examiner

Physician/Medical

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Physician

/Medical

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r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at

with the Maryland

Maryland 21215-0020

altimore,

Peges 1 end 2 should be filed within 72 hant of Health end Mentel Hygiene. Int: If item 27 is marked other than "nati

permit. Peges 1 end 2:
Department of Health er
Important: If item 27 la

other traumatic svent,

attending for the Der signed by the peen page 2 hes certificate director After this Attending Nospital or Attending 24 hours effer death.

Funeral Director: After bletely filled in by the fur

P.O.

Division of Vital

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deat

1 Natural 5 Pending investigation 2 Accident

3 Suicide 6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated. 29b. Signeture ar

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and add 1087

29a. Certifier

31. Date filed (Month, Day, Yeer) APR 23 32. Honistrar's Signature

State Registrar

DHMH 16 Rev 6/95

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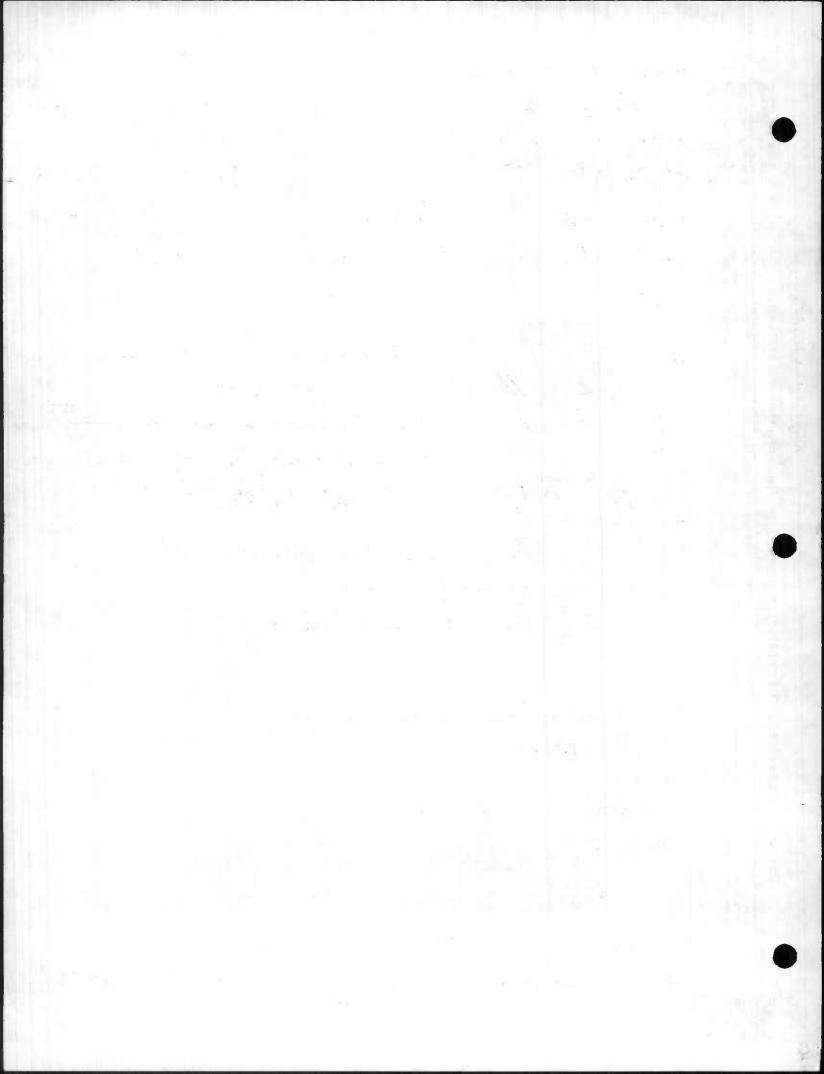
Please Type or Print In Black Indelible ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Item: 19b per F.H G-770 4/23/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Deeth **Physician** /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not Institution, giva street end number) Examiner paryland renkral Baltimore If Undar 1 Yaer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1 M 2 F 244-24-440 Director Usuel Residence of Decedent 10a. Stata 10b. County 10c. City_Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Menleth Hygiene. Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinet man be positived any injury or other traumatic event, its Medical Examinet man be positived. BALLIMORE 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1423 212/6 rove Funeral Wes Decedant Evar In U.S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 11. Marital Status 1 Yes 2 No If Yes, Giva Year or Dates: 1 Naver Married 2 Merried 1 Yas 2 No Specify: Specify: Black p 3 ₩idowed 4 Divorced Be Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 100 GRAde 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21216 19e. Interment's Name/Reletionship (Type, Print) KANdolp chaes 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location · City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility / Cersh Avenue 23e. Part1. Entar tha diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one ceuse on each line. Approximete Intarval Between Onset and Deeth Physician blood culture proteus Mirabilis) /Medical Immediate Ceuse (Finel disaese or condition resulting in deeth) Examiner Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events rasulting in death) Last Box 68760. Physician/Medical P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown þ Division of Vital Records, 24b. Were eutopsy tindings evelleble prior to completion of ceuse ot deeth? 24e. Was en eutopsy performed? Completed 1 Yes 25. Was case reterred to medicel examinar? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of Certification: 28c. Injury at Work? Hospital or Attending P
 24 hours after death.
 Funeral Director: After t 1 Maturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 | Homicide 29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es steted. edical 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. To the F within 2 29b. Signature end title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 12669 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) bud General, Danush Kodi, 31. Dete filed (Month, Day, Year) 32. Régistrar's Signature.

DHMH 16 Rev 6/95

State

Registrar

APR 2 3 1999



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Daeth 3. Time of Death 20 STOTLER APRIL 4e Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death BALTIMORE System If Under 1 Year MARYLAND MEDICAL If Undar 24 Hrs. 8. 6 Say Dete of Birth (Month, Day, Ye 7-16-35 Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Days 1√2 M 2□ F Months Hours 63 Ohio 10d. Inside City Limits 10c. City, Town or Location Baltimore 1X Yes 2 □ No 10g. Citizan of Whet Country? 10f. Zip Code 103 W. Monument St. 21201 USA

Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.)

1 □ Yas 2 No Specify:

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired)

Funeral Director

with the Meryland

Physician

/Medical

Examiner

Director Funeral þ Completed

Be

7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examinar must be notified at Pages 1 and 2 should be filed within 72 hours after deeth viet of Heelih and Mental Hyglene.

Wit: If item 27 is marked other than "natural", or items 23 my or other traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event, if a Yeo caller traumatic event is a Yeo caller traumatic event in the Yeo caller traumatic event permit. Page Depertment of Important: If eny Injury or

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physician and s the buriel-transit The law requires that the death certificate be assouted Physician/Medical attending pl signed by the all d be detached for þ Completed s certificate has b director, Be 2 shr funeral Certification: After death. after death

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physicien: To the Hospital or Atter within 24 hours after der To the Funeral Director complately filled in by th edicai

12. Was Decedent Evar in U,S. Armed Forces? 1 X Yas 2 □ No If Yes, Giva Yaer or Dates; 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Nama (First, Middle, Last) James W. Stotler 19e. Informant's Name/Ralationship (Type, Print) Paul Stotler / brother 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from Stata

ECERIC

10b. County A

of

1 ☐ Nevar Married 2 ☐ Married

4 □ Donetion 5 □ Othar (Specify) 21. Signature of Funeral Service License

Immediata Causa (Final

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated evants rasuiting In death) Last

disaasa or condition rasulting in daath)

5. Social Sacurity Number

10e. Street and Number

11 Merital Status

215-32-3092

Usual Rasidenca of Dacedant

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9900 Van Tassel La., Middle River, MD 21220

Cora Rader

18. Mothar's Nama (First, Middla, Maidan Sumama)

4-22-99

20b. Place of Disposition (Nama of camatery, cramatory or other place) Lorraine Park 22. Nama and Addrass of Facility

Disabled

20c. Location - City or Town, Stata

14. Rece - Amarican Indian,

Black, Whita, atc.

specify: White

16b. Kind of Businass/Industry

Baltimore, MD

23b. Did tobacco uss contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

N/A

Cvach/Rosedale Funeral Home

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

GANGRENE

Due to (or as a consequence of):

Dua to (or as a consaquance of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24e. Was an autopsy

24b. Wara autopsy findings available prior to completion of cause of death?

2 weeks

2 No 1 Yes

1 Yas 2 No

25. Was case refarred to medical examiner? 26. Place of Death (Check only ona)

Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant

6 Could not be 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Location (Streat and Number or Rural Routa Number, City or Town, State)

29a, Cartifiar 10 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signeture end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

4417 6435-1447 April 20

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Rel

ST. BALFO, MID 5. GREENE

31. Data filed (Month, Day, Yaar)

3 Suicida

4 Homicida

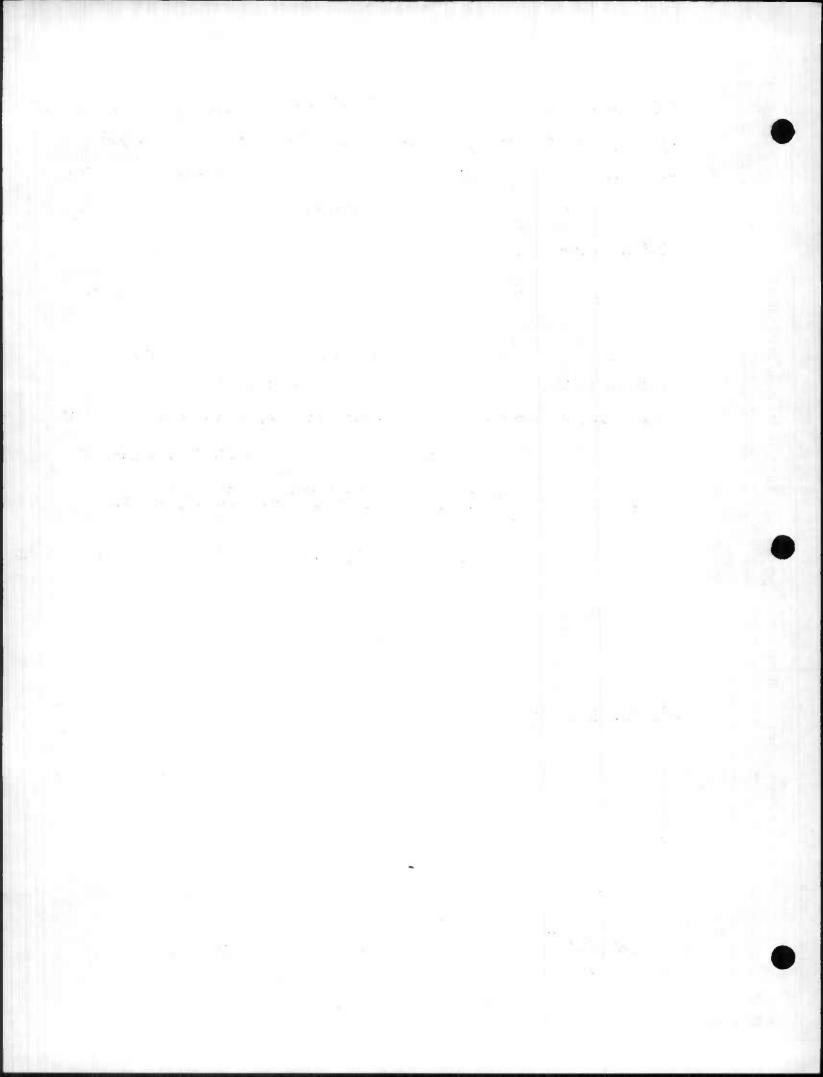
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32. Registrar's Signatura

DHMH 16 Rsv 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 22, Leonetta Μ. 1999 April 9:35PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12121 Boxer Hill Road Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2 F 72 Yrs. 265-40-4577 Director April 17, 1927 Maryland Usuel Residence of Decedent 10s. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2X No Director Baltimore Cockeysville 2 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ð Berns 23a 12121 Boxer Hill Road 21030 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or Specify: White 1 Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Hygiens. Other than 'n Etementery/Secondary (0-12) College (1-4or 5+) 12 Bridal Consultant N/A Clothing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill mant of Health and Mental H lant; if Item 27 is marked off 8 10 William McGill Leonetta Schreyer 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) Department of Health in Important: If Item 27 is any Injury or other tra 2059. Patricia Blevins/Daughter 12121 Boxer Hill Road Cockeysville, MD 21030 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date April 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Baltimore, Washington 4 ☐ Donetion 5 ☐ Other (Specify) 24, 1999 Laurel, MD Crematory 21. Signature of Fuperal Service Dicer 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael Flagle 10 W. Padonia Road Timonium, MD 21093 J. 23a, Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one cause on each fine. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final COPL >10415 disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit tha death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medicai Due to (or es a consequence of): for use as 23h. Did tobacco use contribute to the cause of deeth? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes 25 1 Yes 2 1 No certificate Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 DiNatural death. 1 Tes 2 No 2 Accident Diractor 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 24 hours after d be Funeral Diract bletely filled in by 4 ☐ Homicide ò Hospital 29a. Certifier edical 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 290. Signature and fittle of certifier

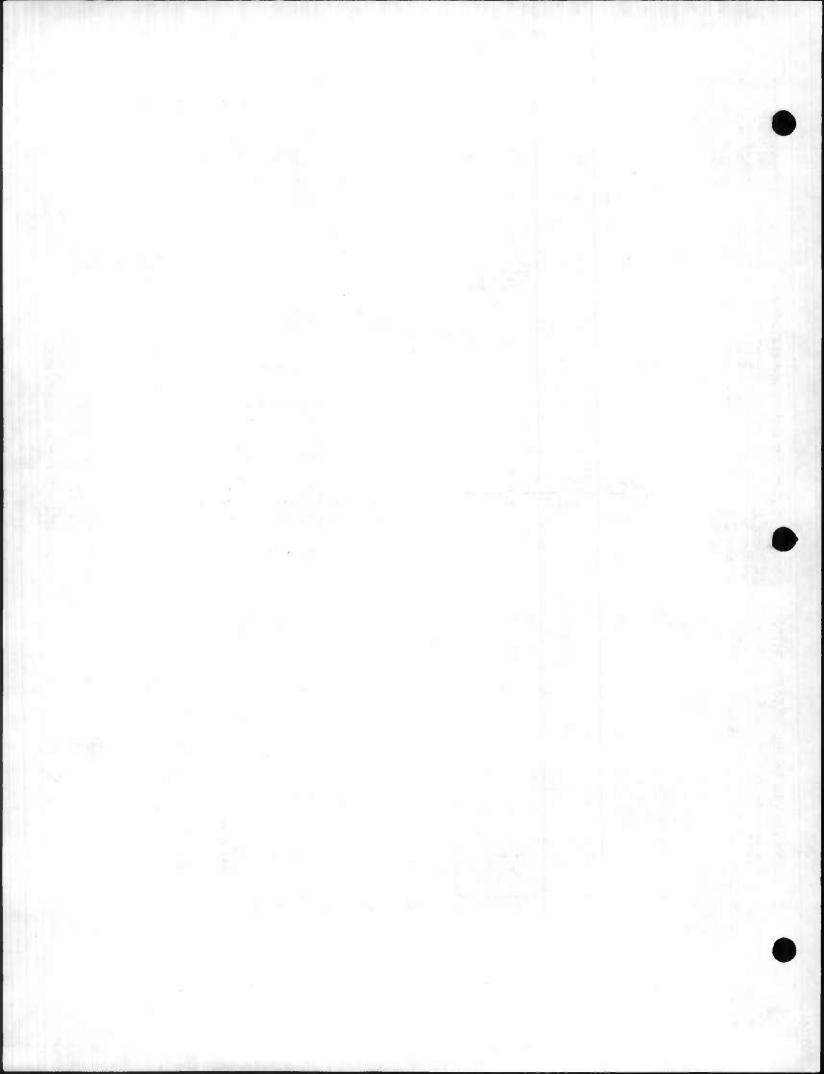
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Attenday Physiciae

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 4123199 015808

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrar's Signature APR 2 3 1999 >

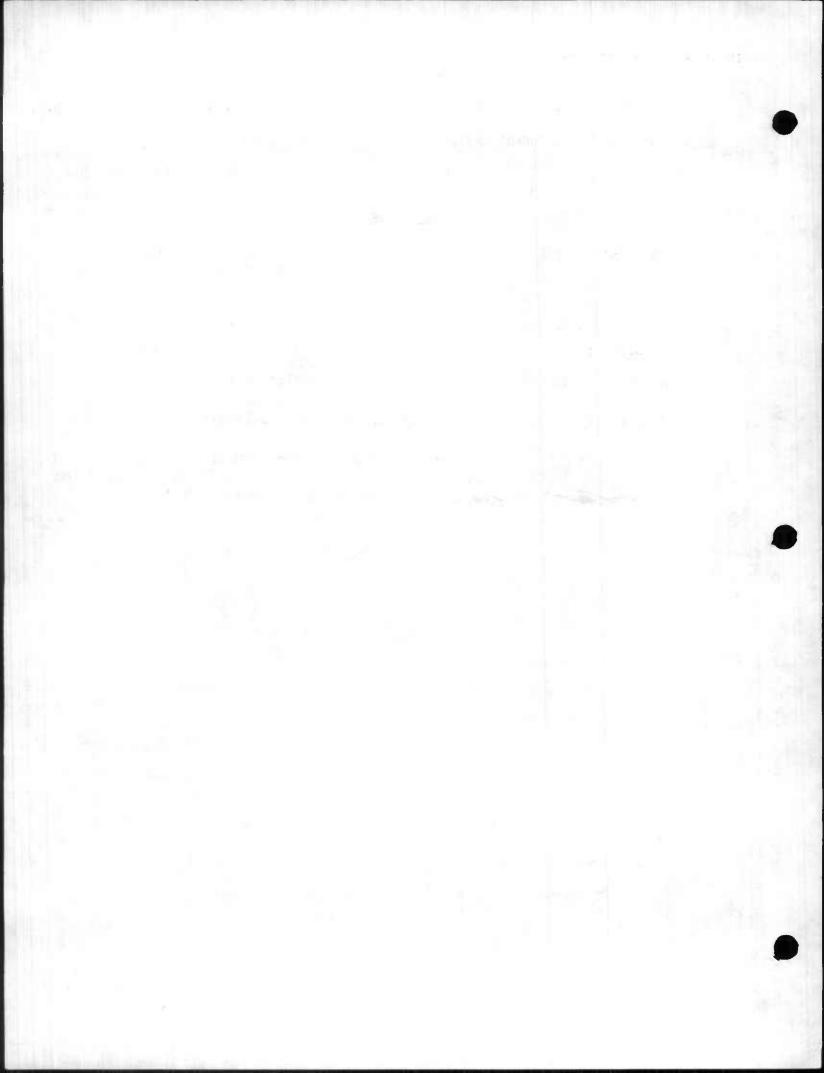
William Randall, M.D. 1205 York Road Suite 33 Lutherville, MD 21093



Item 15 Per FH FilmG770 4-23-99 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Day **Physician** Τ. April 22,1999 MARY 10 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CANTON HARBOR HEALTHCARE CENTER BALTIMORE If Under 24 Hrs. 8.1 If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Data of Birth (Month, Day, Year) **Funeral** Days Months 1□ M 2XXF Hours Yrs 214-03-4284 80 Director May 28, 1918 MARYLAND Usual Rasidance of Dacedant the Maryland 10a Stata 10h County 10c. City, Town or Location 10d Inside City Limits show 1 X Yas 2 No Director N/A BALTIMORE 288-4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? à Norma 23a 3603 FAIT AVENUE 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 Navar Married XX Married 1 ☐ Yes AXNo Baltimore, Maryland 21215-0020 Specify: WHITE 'natural', or 1 ☐ Yas 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 10 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Mental Important: If hem 27 is marked of any injury or other traumatic av once. Fleckenstein Helen Thomas 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Jane Welzant 4234 E. Joppa Road, Baltimore, Maryland 21236 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 D Burial 2 Cramation 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Sacred Heart of Jesus Cemetery April 26 1999 Dundalk Maryland 21. Signature of Funaral Sarvice Licensas 22. Neme and Address of Facility Lilly & Zeiler, Inc. Funeral Home 700 S. Conkling St., Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) Examiner Physician/Medical Examiner 020 physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarfying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Delous VAT when Dua to (or as a consequence of): Artenio sil Milla Dilm Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 2 Onknown 1 ☐ Yes 2 ☐ No DEmark should be det Division of Vital Records. by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 HNO 1 Yes No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical staty filled in by the funeral director, 25. Was case refarred to medical axaminar?

1 Yas 2 Be 26. Place of Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Datural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida a Funeral I 29a. Certifier 1 Tottifying Phyalcian: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. (Check only one) within 2 To the 29b. Signetura and win of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) de 31. Dete filed (Month, Day, Year) APR 2 3 1999 32. Registrar's Signature State Registrar

AHB



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death WRIGHT / Month 0:26 9 4c. County of De 4a Eacility Nama (If not institution, giva street and number) imore 5. Social Security Number 6. Sex 7. Aga (In vrs. last birthday) 2-32-227 Days 1□M 2XF Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, Whita, atc. 1 Nevar Married 2 Married If Yas, Giva Yeer or Detes: 1 ☐ Yes 2 No Specify: Negro 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Home omema Ke 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) Informant's Name/Reletionship (Type, Print) (Niece) 19b. Mailing Addrass (Street and Number of Rural Routa Number, City or Town, Stata, Zip Code) Mar 20b. Place of Disposition cematery, cramatory 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from State 4 Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Famility JOSEPH L. RU 2722 W. Nort ire of Funeral Service License Home uneral Ave. th ane, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at List only one cause on each line. CARDIAC Immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) SC Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 1 Yes 2 2000 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 540 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending invastigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

Examiner attending physician and for use as the burial-trans 88 After or Attending

Physician/Medical Ą Completed Be Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

6 Нете 23а

permit. Pages 1 and 2 should be fited within 72 hours after to Department of Hear th and Mental Hygiene.

Important if Item 77 is marked other than "natural", or then any injury or other traumafic avains.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

Director

Funeral

py

Completed

Box 68760 Division of Vital Records, P.O. n 24 hours after death.

Ne Funeral Director: Aft pletely filled in by the fur vithin 24 hour

> State Registrar

DHMH 16 Rev 6/95

29b. Signatura and little of certifian

(Check only one)

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) MISACITEN

29c. License number

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

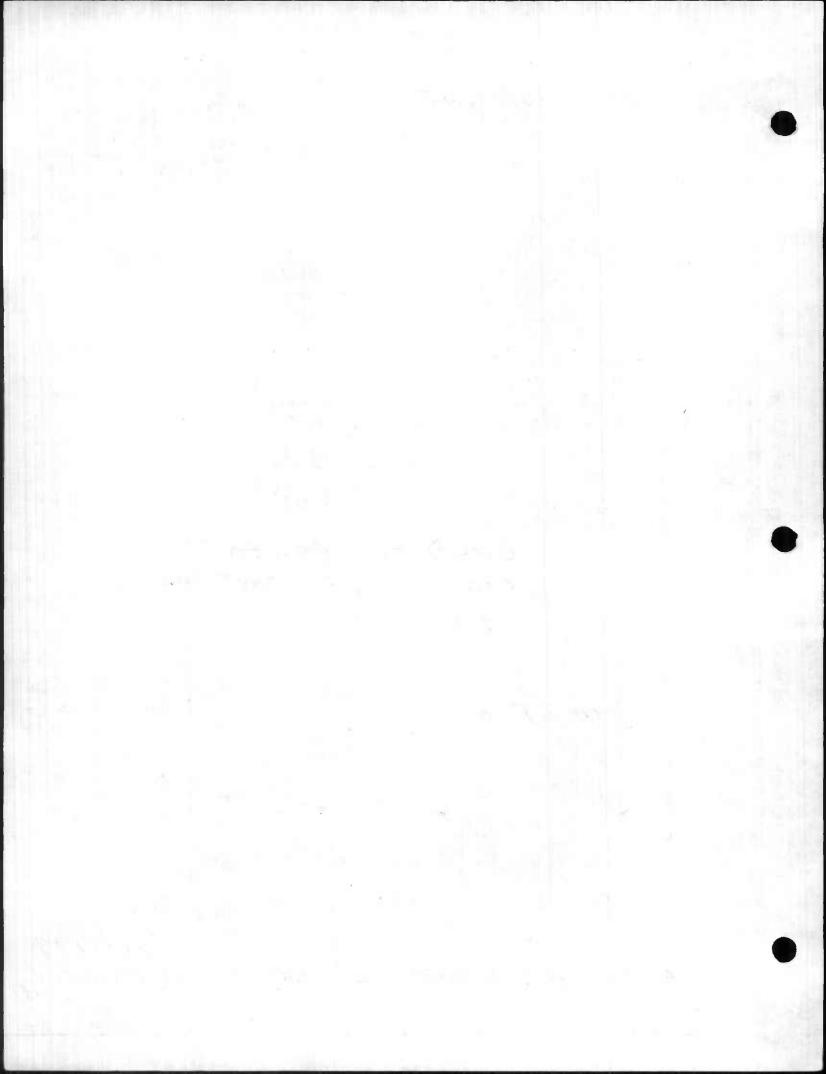
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MARYLAND AVE

31. Deta filed (Month, Dey, Year)

32. Registrar's Signatura

ORIGINAL

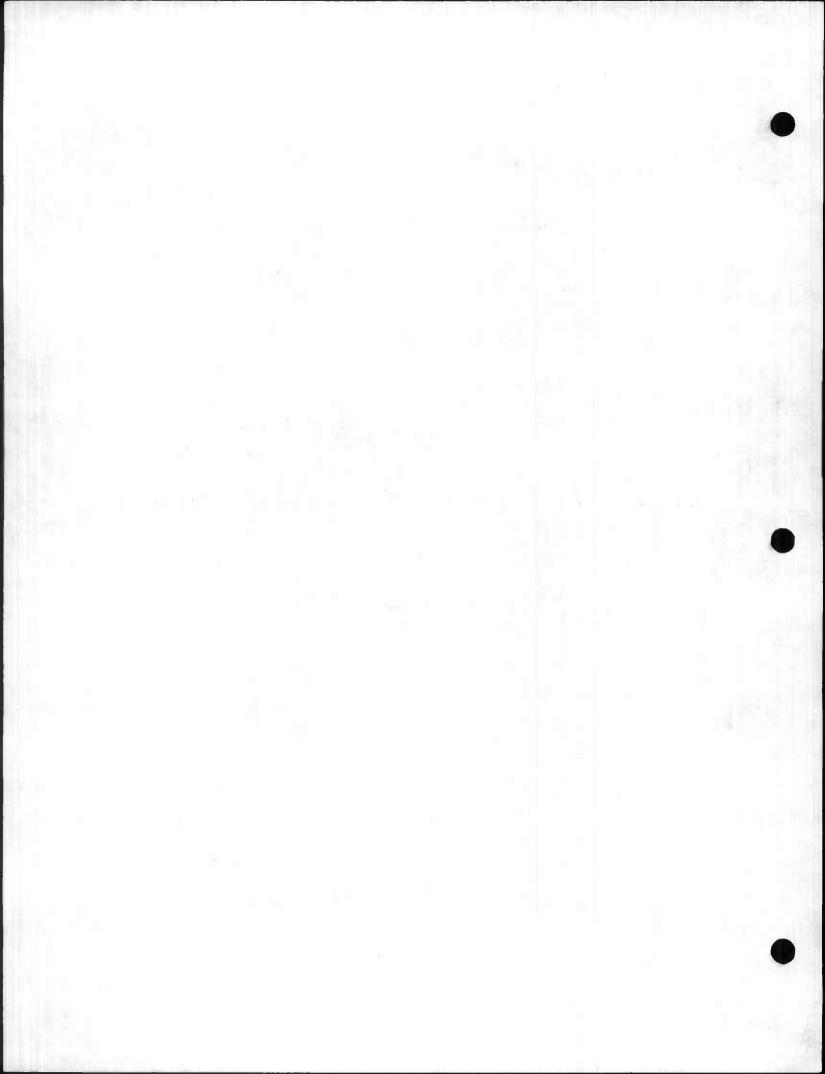


State of Maryland / Department of Health and Mental Hygiene

| ICONYA WII | !LC | alls | | C | ertificate of | Death | Re | ig. Nő. | 13 | 396 |
|---|-----------------|---|---|---------------------------------------|---|---|-------------------------------------|--------------------|-----------------------|---|
| Dhomisi | | 1. Decedent's Name (First, Middle, La | 51) | | | | 2. Date of Deat Month | h | Year | 3. Time of Death |
| Physicia /Medic | al _ | Lalonya | M. Will | Iam. | S | | April 2 | 21, 1999 | | 7:00 A.M. |
| Examin | er 4 | la Facility Name (If not Institution, giv | | 105 | | 4b. City, Town, or I | | 4c. County of | | |
| | | North-bound I-95 | | | I Killedge 1 Vons | Catonsvi | | | imor | |
| Funeral Director | | 5. Social Security Number 594-07-4907 Usual Residence of Decedent | 10 M 2 A F 3 | In yrs. last birthd | Months Days | | 8. Date of Birth (Month, Day, | 1968 | 9. Birthple | ace (State or Foreign n) 1 d a |
| yland | | 10a. State 10b. County | 1 1 | Oc. City, Town or | Location | | | | 10 | d. Inside City Limits |
| the Mar 28a-f si | Director | Florida DUV | a | Jack | SONVII | le | 14 | Og. Citizen of Wh | net Count | 1 Yes 2 X No |
| 5-0020 72 hours effer death with the Maryland natural, or Name 23a or 28a-f show are Examinat mast be notified at | ral Dir | 4673 Sur | ay Ave | | 326 | 208 | | US | A | |
| ter de | Funeral | 11. Marital Status 1 ☐ Never Married 2 Married | 12. Was Decedent Event Armed Forces? 1 ☐ Yes 2 🔀 No | er in U,S. | Was Decedent of If Yes, specify Cut | Hispanic Origin? (S an, Mexican, Puert | o Rican, etc.) | 14. Race Black, | - America White, e | |
| 020 Jrs eff | by F | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ဩ No | Specify: | | Specify: | RIA | ck |
| 72 hours | B | 15. Decedent's E | | 16a. De | cedent's Usual Occu | pation | 44 | 16b. Kind of Bus | iness/Indi | ustry |
| T S 1.5 | Completed | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5+) | | cedent's Usual Occu ive kind of work done e DO NOT use retire | id) | xing | D | | 11. |
| | S | 12 | 0 | /\ | lanage | er | | BULG | ger | King |
| be filed that the dother went. | Be | 17. Father's Name (First, Middle, Last | taging | | | 18. Mother's Nan | ne (First, Middle, A | Maiden Surname, | 4 | 5 |
| rylan nould be d Mentel nerked o | 2 | 11 Inur 1 | riomas | 1 100 10 | | LUIA | - HUI | 151 | | |
| Maryland d 2 should be flie th and Mentel Hy 7 Is marked othe treumatic event | | 19a. Informant's Name/Reletionship | Type, Print) (mothe | 190. M | eiling Address (Stree | TALL ALLO | Tank C | An Will | tare, Zip | · / 222A |
| * ra la 7 | 1 | 20a. Method of Disposition | IUITIUS | 20b. Place of Di | sposition (Name of | LY TIVE. | Date : | 20c. Location - C | city or Toy | 711019 |
| 5 85 = 9 | | 1 Burial 2 Cremation 3 C | | Edge! | crematory or other pla | motory (| 5/1/99 - | TARKEN | will | la Ehrid |
| Saltin emit. Pe epartmer reportent: ny injury nce. | 3 | 21. Signature of Funeral Service/Lice | | Lager | 22. Name and Addr | ess of Facility | | achson | 10111 | E/1 10/14 |
| Balt pemit. Departr Imports any inj | | · Joseph | L. Ku | 15 | Joseph | North | Ave. B | ral H | ome d. 2 | 1216 |
| | | 23a. Part. Enter the disease, or com shock or heart failure. List only | plications that caused the one cause on each line. | e death. Do not | enter the mode of dy | ing, such as cardiac | or respiratory sme | est, | | Approximate Intervat Between |
| Physician / | | Immediate Course (Final | | | | | | | i | Onset and Death |
| Examiner | | tmmediate Cause (Final disease or condition resulting in death) | a. Mu | utiple | injuri | 15 | | | - ! | |
| | 00 | | Du | ue to (or as a con | sequence of): | | | | 1 | |
| 60, the executed sician and buriel-transit | edicai Examiner | Constallation and discount | b | e to for on a con | enaunana afti | | | | i | |
| D, exec an an | Exa | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | Di | e to (or es a con | sequence ory. | | | | 1 | |
| 68760, ificeta be execut g physician and as the buriel-trar | cai | that initieted events | c | e to (or as a cons | sequence of): | | | | - | |
| | - | resulting in death) Last | d | | | | | | t | |
| deeth cert e attendin | Physician/W | Ont II. Other elgolificant and distance | antalkuting to death but o | and consideration to the | | in Bod I | non Dida | | l l | the cause of death? |
| d by the detached | hys | Part II. Other algnificant conditions of | ontributing to death but i | not resulting in th | e underlying cause g | ven in Part I. | | | | the cause of death? ably 4 Unknown |
| | | | | | | | | 2 2 20,140 | 0_1.00 | ably 4 divisions |
| Of VItal Records, P.O. BOX Physician: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use | Completed by | | | | | | 24a. Was as perform | | ava | re autopsy findings ilable prior to apletion of cause |
| has b | Idu. | | | | | | | | | leath? |
| in The icate h | 8 | | 1 5 5 1 | | | | 1.12 Ye | s 2 No | 1.23 | Yes 2□ No |
| Of VIIa Physician: ribis certific and director, | □ | 25. Was case referred to medical axaminer? | Hospitel: | | _ 0 | | ath (Check only on | | | |
| Phys oral di | OT :1 | 1 X Yes 2 No 27. Manner of Death | 1 ☐ Inpatient | 2 ER/Outpa | tient 3LI DOA | 4 Li Nursing h | lome 5 ☐ Reside 28d. Describe ho | | | at scene |
| LIVISION I or Attending after death. Director: After din by the fune | tion | 1 □Naturat 5 □ Pending 2 ☑ Accident investigatio | (Month, Day Y | | 414 15 | ork?]Yes 2,MZNo | | | | dun t |
| After dea | ifice | 3 Suicide 6 Could not b | 9 28e. Place of Injury | - At home, farm, | street, factory, office | | 281. Location (St | | | Royte Number, |
| D Para | Certification: | 4 Homicide | building, etc. (| reet | | | Baltimore | | | / |
| DIVISION OF VITAL Hee To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | | | ysicien: To the best of n | ny knowledge, de camination and/or | | | , and due to the ca | use(s) and man | ner as str | sted. |
| thin the | | 29b. Signature and title of certifier | and manner state | 9. | 29c. Licen | se number | 20 | 9d. Date signed | (Month f | Dav. Year) |
| F. ¥ F. 8 | | 1 - 1 | 1 | 1- | | C.M.E. | | pril 21 | | |
| | | Mysh. | N V La | de, | unp | | | Town er | , | |
| | 3 | 00. Neme and address of person who | | | | n Street | Raltimo | me Mar | w] an | d 21201 |
| Stat | te 3 | Stephen S. B1. Date filed (Month, Day, Year) | 2 adent Z 32. Registrar's | Signature | 111 101 | ar ouleet | , DULLUIK | re, rat | у теп и | 4 21201 |
| Registra | | APR 2 3 1999 | Serve | | Some 1 | | | | | |

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sanno dil /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Win hester nor nator 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex If Under 1 Yeer If Unde ace (State or Foreign **Funeral** 12-2808 Months Deys Hours 10 M 20 F lanc Director Usual Residence of Decedent with the Maryland 10e. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show mant be notified at TOYes 2 No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2 2 "natural", or items 23s 0 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indien, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If them 27 le marked other than "natural", or harny injury or other traument. Black, White, atc 1 Never Married 2 Merried Baltimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify If Yas, Give Year or Dates: p Vegr 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) memak 10 9 Vat 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be samue 19b. Mailing Addrass (Street and Number or Rural Route Number, 19a. Informant's Neme/Reletionship (Type, Print) (daughter) City or Town, State, Zip 3.5e Son Vd. ne TO 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other) 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from State Memoria 4 ☐ Donation 5 ☐ Other (Specify) 0 22. Neme end Address of Fecility OSEPH L. R.U.S 2222 W. Nor cility, USS re of Funeral Servide Licens Parto. Joseph uneral Ave. 2/2/6 22 or complexions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** /Medical Immediate Cause (Fine disease or condition resulting in death) Examiner Due to (or as a co Examine physician and the bural-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated Dua to (or as a cont Division of Vital Records, P.O. Box 68760, Physician/Medical I that initieted events resulting in death) Last Due to (or as a consequence of): for use as 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yea 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Wes an autopsy performed? Completed peen s completion of cause of death? page 2 has 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only ona) Other: 1 Yes 218 No edical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 2 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? : After t 5 Pending investigation within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide vothe Hospital or within 24 hour 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only ana)

State Registrar

29b. Signature and title of certifies

MAR 31. Date filed (Month, Day, Year)

ne and address of perso

3 1999

DHMH 16 Rev 6/95

ORIGINAL

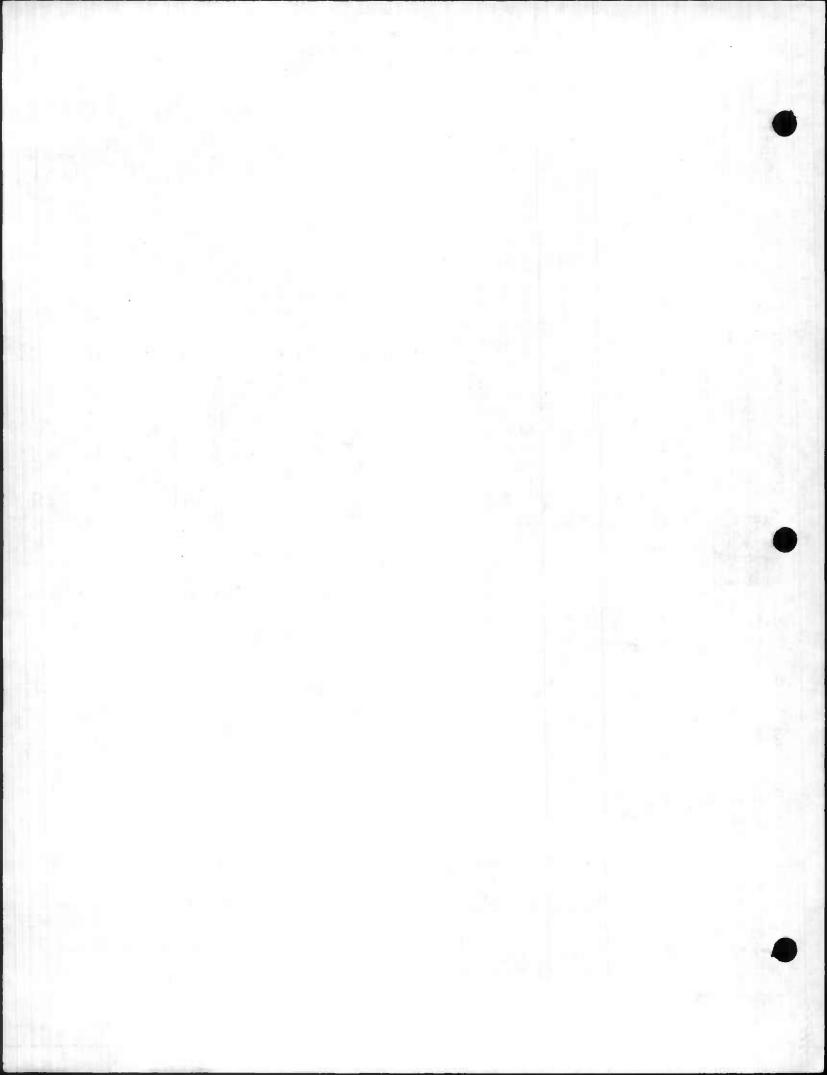
death (Item 23a) (Type, Print)

Visvarne

Registrar's Signature

29c. License number

29d. Deta signed (Month, Dey, Year)



| | | | State of Maryla | | rtificate | | | | | Reg. No. |) | 10034 |
|--|------------------|--|--|------------------------------|------------------------------|----------------------|------------------|-------------|---|---------------------|-------------------|---|
| Physic | ian | 1. Decedant's Neme (First, Middle, Last | | 2. Dete of Dee Month | eth Dey | Year | 3. Time of Death | | | | | |
| /Med | | NANNIE MAE WIL | LIAMS | | | | | | APRIL | 21, 1 | 999 | 3:48PM |
| Exami | ner | 4a Facility Name (If not Institution, give | | | | 4b. | City, Tow | m, or Loc | ation of Death | 4c. County | of Deeth | |
| | | GREATER BALTIMOR | | | If Under 1 | | TOWSO | | Data of Die | | IMOR | |
| Funeral Director | | 5. Sociel Security Number 6. Se 223-70-3377 Usuel Residence of Decedent | TM 997 E | rs. last birthday 19 Yrs. | | Deys | Hours | Min. | 8. Dete of Birt Month, Par 4-30- | 49" | POW | HATAN VA |
| snyland show dat | | 10e. State 10b. County A | 10c. | City, Town or L | | | | | | | | 10d. Inside City Limits |
| ar death with the Marylar items 23s or 25s-f show ner must be notified at | Director | 10e. Sfreet and Number | | BALT | IMORE, | | | | | 10g. Citizen of 1 | What Cou | |
| n with | | 4413 ELDERON AV | Æ | | 21 | 1215 | 5 | | | τ | J.S. | A |
| Can de | Funeral | 11. Maritai Status | 12. Was Decedent Ever In | U,S. 13. | Wes Deceden | nt of Hisp | penic Origi | in? (Spec | ify Yes or No | | | can Indien, |
| urs after af, or its | by Fu | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 Yas 2 No If Yas, Give Yeer or Dates: | | If Yes, specify 1 ☐ Yes 2 ② | | Specify: | Риепо н | ican, etc.) | Specify | ck, White, | LACK |
| 72 ho neturn disal i | eted | 15. Decedent's Edu (Specify only highest grad | | (Give | edant's Usual C | done du | ion ring most | of working | 9 | 16b. Kind of B | usiness/ir | dustry |
| s within plans. r than | Completed | Elamantary/Secondary (0-12) | College (1-4or 5+) | | ING AS | , | STAN | Т | | NURSI | ING HOME | |
| othe other | Be C | 17. Fether's Neme (First, Middle, Last) | | | | 1 | 8. Mothar | 's Nama | (First, Middle, | Maiden Suman | ne) | |
| Menta Menta rriced rife e | ToB | WILLIAM MORRIS | | | | | J | ULI | MORF | RIS | | |
| nd 2 sho lift and h 27 is ma r trauma | No. | 19a. Informent's Name/Reletionship (7) KEITH WILLIAMS | (HUSBAND) | | ing Address (S 3 EI,D) | | | | | MD 2 | State, Zi 2120 | |
| ges 1 a or other | | 20e. Method of Disposition 1 Burial 2 Cremation 3 DF | Removal from Stete | * ' | matory or other | er place) | | 37 | Data 1 | 20c. Location | | |
| Semit. Pa Separtmer mportant any injury ance. | | 4 Donetion 5 Other (Specify) IJITTLE ZION CEMETERY 4-26-POWHATAN, VA 21. Standard of Facility | | | | | | | | | | VA |
| Dep firm anny | | 23e. Pert1. Enter the disease, or compl shock, or haart failure. List only or | icetions that caused the do | J I. | EROY O | O D' | YETT TY H | & S GHTS | S AVE | JNERAL, BALTO | | E D 21207 Approximate Interval Between |
| Physician /Medical | | Immediate Ceuse (Finel | Acute lu | 1 | - | , | | | | | | Onset and Deeth |
| Examiner | 20 | Due to (or es e consequênce of): Metastatiz Colon Cancer | | | | | | | | | 1 | 1 VPOC |
| executed in and hal-transit | Examiner | | | | | | | | | | i | 1/1/11 |
| ate be executed hysician and the bunal-transit | al Ex | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury c. | | | | | | | | | | |
| certificate be ding physicia ise as the bui | Aedical | that initiated events resulting in death) Last | Due fo | (or es e conse | quence of): | | | | | | 1 | |
| - 5 - | lan | | j | | | | | | | | | |
| . 0 00 | Physician/Me | Pert II. Other significant conditions con | ntributing to death but not i | resulting In the | undarlying cau | isa given | In Pert I. | | | yes 2 No | | o the cause of death |
| law requires that the as been signed by the 2 should be detach: | eted by | | | | | | | | | en autopsy rmed? | en C | are eutopsy findings vailable prior to empletion of cause |
| | Completed | | | | | | | | 10 | res 20No | | death? ☐ Yes 2☐ No |
| an: T tificet tor, p | 0 | 25. Wes case raferred to medical | | | | | 26. Place | of Death | (Check only o | | | |
| Physician: rthis certific aral director, | To B | exeminar? 1 ☐ Yes 2 ☑ No | fospitel: 1 Inpatient 2 | ER/Outpatie | ent 3 DOA | Other | | | | tence 6 Oth | ner (Speci | (fy) |
| ding Physith. : After this stuneral di | Certification: 1 | 27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation | 28e. Dete of Injury (Month, Day Year | 28b. Time Injury | of 280 | i. Injury 8 Work? | at es 2 N | | 28d. Dascribe how injury occurred | | | |
| or Attending after death. Director: After in by the fun- | | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edical Co | | sicien: To the best of my k ner: On the basis of exam end menner stated. | | | | | | | | | |
| To the Within To the | M | 29b. Signeture end fittle of certified | dua no | | | License | | | | 29d. Date signe | 199 | Day, Year) |
| | | 30. Nema and address of parson who co | | tem 23a) (Type | | -/ | 120 | B | estimo | هر و | 36 | 08 |

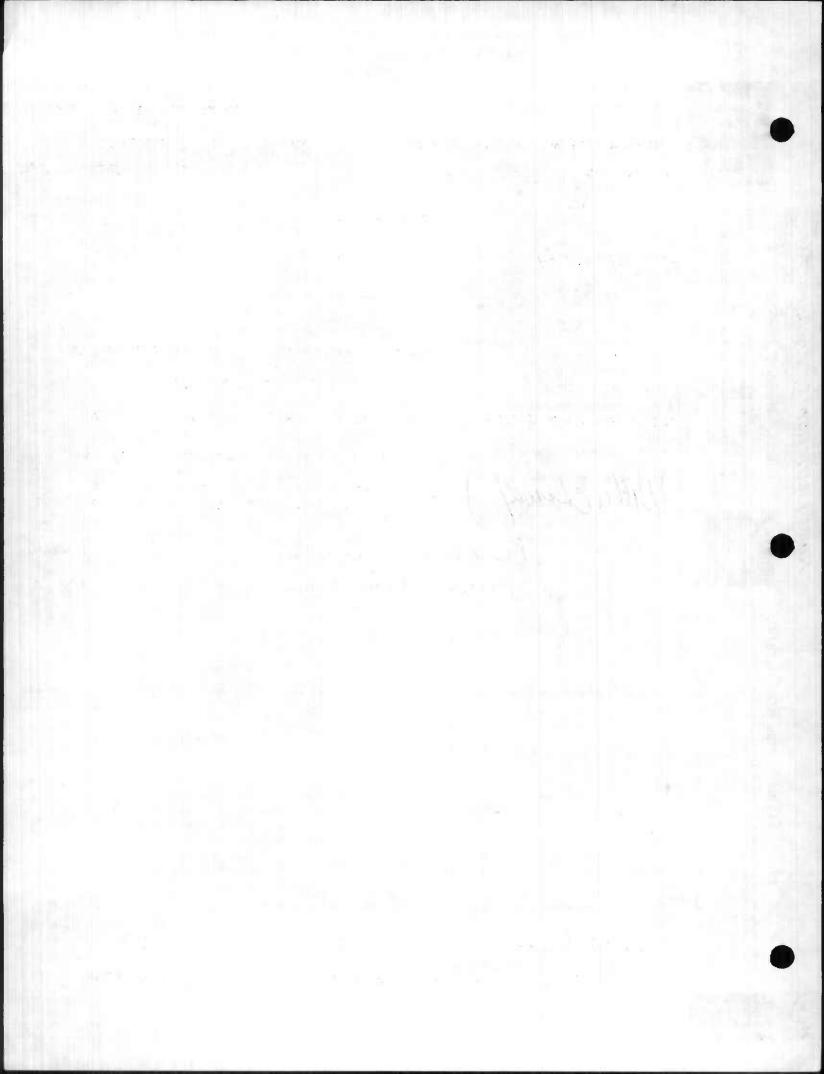
NAME: Williams, Nannie M.

State Registrar

31. Dete filed (Month, Day, Year)



Sporks



3. Time of Death

10d. inside City Limits

Approximata Intarval Betwaan Onsat and Death

3 Probably 4 Unknown

24b. Wara autopsy findings availabla prior to complation of causa of daath?

1 ☐ Yas 2 ☐ No

1 Yas 2 No

720 AM

Physician /Medical Examiner

Funeral Director

item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Madical Examinat must be notified as 00 Hygiene. Mentel should be Important: if them 27 is n any injury or other in-

MADELINE

altimore,

Physician /Medical **Examiner**

physician and the buriel-transit certificate be 80 980 2 pege 5 certificate has After this funeral

py

Completed

Be

2

Certification:

edicai

State

Registrar

1 Natural

4 Homleida

(Check only one)

29a. Cartifian

Box 68760, P.0. Records, Division of Vital or Attending Physician: after death. filled in by 24 hours a Hospital within 2 the

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Month Madeline Myrtle Whitlock APRIL 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death N/A SINAI HOSPITAL OF BALTIMORE BALTIMORE If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foraign
Country) 6. Sax 7. Aga (In yrs. last birthday) Days 1□ M 2XF 217-52-7110 93 June 12, 1905 West Virginia Usual Rasidance of Dacadant 10a Stata 10b. County 10c. City, Town or Location Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 6811 Campfield Rd. 21207 United States Funeral 12. Was Decedent Evar in U,S Armed Forcas? 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 Navar Marriad 2 Married 1 ☐ Yas 2XX No Specify: white à 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Coltega (1-4or 5+) homemaker own home 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Christopher Fletcher Martha Oates 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2611 W. Marine Ave. Lawrence Whitlock/son Baltimore, MD 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 N Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4/24/99 4 ☐ Donation 5 ☐ Othar (Specify) Oaklawn Cemeterv Baltimore, Maryland 21. Signatura of Funarai Sarvica Licensaa 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home 6500 York Rd. om b. 21212 Baltimore, MD art1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. immediata Causa (Final disaasa or condition rasulting in daath) a INTRACEREBRAL BLEED WITH CONTUSION Dua to (or as a consaquance of): Examiner ANEMIA Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of) Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PIABETES

SEIZURE DISORDER

25. Was casa rafarrad to madical axaminar? 26. Placa of Daath (Chack only ona)

1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 5 Panding invastigation 2 Accident 3 ☐ Suicida

Hospital:

6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

1 Yas 2 No

28b. Tima of

3 DOA

28c. Injury at Work?

29c. Licansa number

🄼 Cartifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

1 TYes 2 No

20 No

Location (Street and Number or Rural Routa Number, City or Town, Stata)

24a. Was an autopsy performed?

28d. Dascribe how Injury occurred

29b. Signatura and titla of cartifiar

AS 2402321-589206

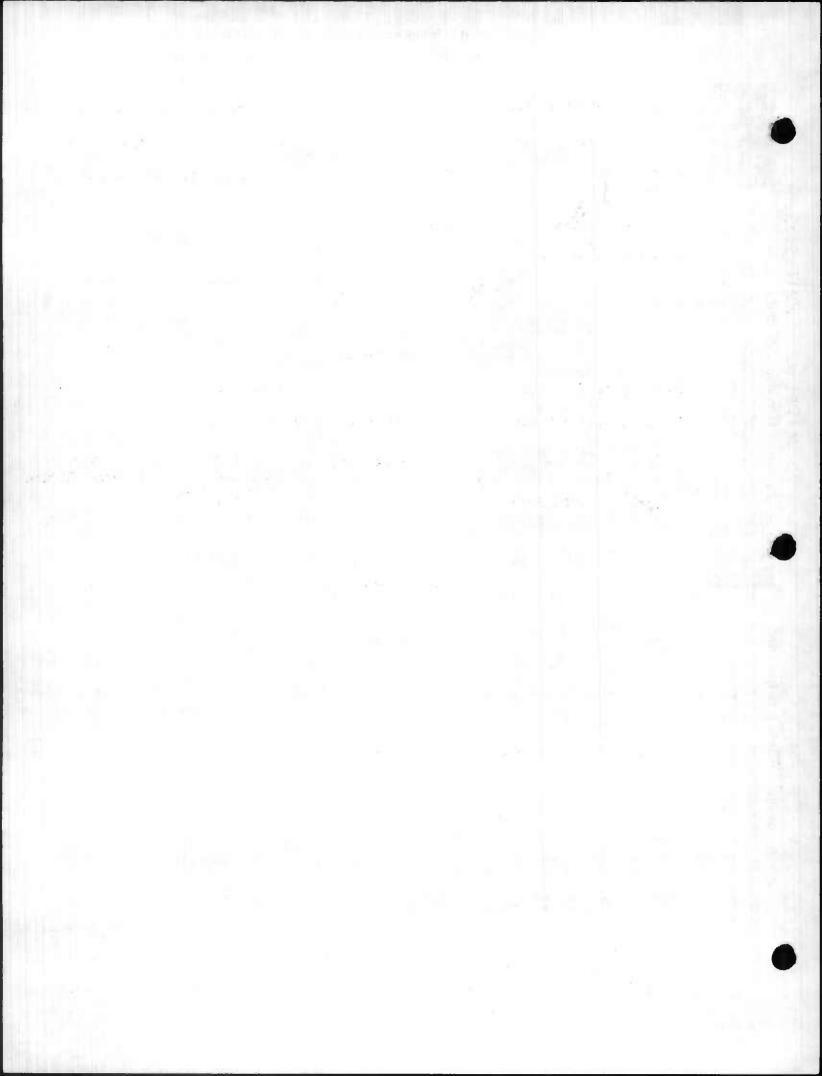
29d. Data signed (Month, Day, Year) APRIL 19, 1999

WO 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

WEST 2401 31. Data filad (Month, Day, Year)

APR 2 3 1999

WEBERE AVENUE, BALTIMORE, MARY LAND 21209 32 Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death

MD 21239

| | | | | - | , imouto c | , Douil | 1 | neg. No. | | | | |
|------------|---|---|---|--|---|---|--|---|--|---|--|--|
| ı | Physician /Medical | | HURLO | CK | WRI | GHT | 2. Date of D Month APRIL | Day 23 | 1999 | 3. Time of Death 3:05 AN | | |
| | Examiner | 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. Cou | | | | | | | ounty of Deeth TIMORE CITY | | | |
| | Funeral Director | 213-48-2751 | _ 12 | yrs. last birthdey Yrs. | Months Da | ear if Under 24 Hr lys Hours Mir | 8. Date of Bi (Month, D May 3 | I, 1910 | Count | ace (State or Foreign Pland | | |
| | ahow | Usual Residence of Decedent 10e. State 10b. County MD | 100 | c. City, Town or I | Location | | | | 10 | od. Inside City Limits | | |
| | th with the Meryler 23e or 28e-f show 23e or 28e-f show | 10e. Street and Number | | Darc | 10f. Zip Coo | de | | 10g. Citizen of | What Count | | | |
| | 23a o | 11.5 E. Melrose Ave. 21212 USA 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amelity Yes, Specify Cuban, Mexican, Puerto Rican, etc.) | | | | | | | | | | |
| 020 | 72 hours after death with the Meryland nature!; or items 23a or 28a-1 show ites! Exerting the notified at the by Funeral Director. | ₩idowed 4 Divorced | Armed Forces? | in U,S. 13 | I. Was Decedent If Yes, specify (1 ☐ Yes 2 ▼ | | Specify Yes or N rto Rican, etc.) | Bla | ce - America ick, White, e by: Whi | etc. | | |
| 21215-0020 | | 15. Decedent's (Specify only highest) Elementary/Secondery (0-12) | Education trede completed) College (1-4or 5+) | (Giv | 16e. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired) Owner | | | | Business/Industry Estate | | | |
| | be filed tal Hyg d other event, | 17. Fether's Name (First, Middle, La | • | | | 18. Mother's N | ame (First, Middle | | me) | | | |
| Maryland | Men Men To | C.Harl | an Hurlock | | | | ell Da | | 0 | 0-41 | | |
| Mai | nd 2 sho lth end 27 le m | 19a. Informant's Name/Relationship E. Kingdon Hu | | 929 | | tt Road, | | | | | | |
| Baltimore, | 0 0 - 2 | 20a. Method of Disposition 1 ABunal 2 Cremetion 3 4 Donetion 5 Other (Spe | Demoval from State | 0b. Place of Disposeries, cr | position (Neme or remetory or other | f | Date | 20c. Location | - City or Tox | wn, State | | |
| Balti | parmit. Peg Department Important: I any Injury o | 21. Signeture of Funeral Service Lic | ensee | | 22. Name and Ad Mitche 6500 Y | ddress of Fecility 11-Wiede ork Road | feld F | uneral | Home | , Inc. | | |
| | Physician | 23a. Pert1. Enter the disease, of co shock, or heert failure. List or | mplications thet caused the ly one cause on each line. | deeth. Do not e | nter the mode of | dying, such as cardi | ec or respiretory | arrest, | | Approximete Interval Between Onset end Deeth | | |
| | Physiclan /Medical Examiner | immediate Cause (Final disease or condition resulting in death) | e. Pue | neun to (or as e cons | | | | | - | Z week | | |
| Н | Sit and | | b | b. | | | | | | | | |
| 60, | icate be executed physician end s the buriel-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury | Due c | Due to (or es a consequenca of): | | | | | | | | |
| ox 68760 | ding se e | that initiated events resulting in death) Lest | Due d. | Due to (or as a consequence of): | | | | | | | | |
| m | the atter thed for u | Part II. Other significant conditions | contributing to death but no | ot resulting in the | underlying caus | e given In Pert I. | 23b. Die | i tobacco use c | ontribute to | the ceuse of death | | |
| s, P.O. | = 00 > | Chronic ob | structive p | pulmon | ary d | sease | 10 | Yes 2 No | 3 Prob | pebly 42 Unknow | | |
| Records, | s been s 2 should | | | | | | | performed? eveilable pri | | ore eutopsy findings eilable prior to mpletion of cause death? | | |
| al R | The la | | | | | | 1 | Yes 20 No | 10 | Yes 212 No | | |
| Vital | Physician: The this certificate ral director, pag | | Hospital: | 2 ☐ ER/Outpeti | 2 DOA | Other: | eath (Check only | | har (Specifi | А. | | |
| of | Jing Ph J. After thi funeral | | 1 ☑ Inpatient 28a. Dete of Injury (Month, Day Yellion | | of 28c. | Injury at Work? | | Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred | | | | |
| Division | To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could no 4 Homicide determin | 289. Placa of injury - | 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | | | ber or Aura | I Route Number, | | |
| | n 24 hours ne Funeral pletely fille | 29a. Certifier 1 Certifying (Check only one) | Physician: To the best of my aminer: On the basis of exa and menner stated. | y knowledge, dec minetion end/or | eth occurred et the investigetion, in r | ne time, dete end ple my opinion, deeth oc | ce, and due to the curred et the time | e cause(s) end n o, date end place | nanner as st , end due to | eted. the ceuse(s) | | |
| | within To the comple | | 2.13 11.01.7101 318.100. | | 0 | cense number | | 29d. Dete sign | | | | |
| | | > NOCT | ا العما | M.D. | F | 11402 | 2 | APRIL | 23, | 1999 | | |
| | | 30. Name and address of person wh | o completed cause of death | (Item 23a) (Type | e, Print) | | | | | | | |

WILLIAM IMBEAH, GOOD SAMARITAN HUSPITAL, SOOI LOCK RAVEN BLVD, BALTIMORE,

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Dey, Year)
APR 2 3 1999

MILITARY COLUMN 10-1010 C The Land THE RESERVE TO LOS TO THE PARTY WAS A TO THE

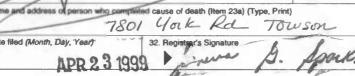
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State of Maryland / Department of Health and Mental Hygiene

| | | Certifica | ate of | Death | | Reg. No. | 2 | 3391 |
|--|---|-------------------------|-------------------|---|-------------------------------------|-------------------|-------------------------------|--------------------------------------|
| 1. Decedent's Name (First, Middle, La | | | | | 2. Dete of Dea | Dey | Yeer | 3. Time of Death |
| al Joseph Affred | | r. | | | April | 20 | 1999 | 6:20 AM |
| er 4a Facility Name (If not institution, give | | | | 4b. City, Town, or I | | D - 141 | | |
| 1801 Glencoe Roa 5. Social Security Number 6.5 | | foot birth days) M Un | der 1 Yeer | Sparks If Under 24 Hrs. | | Baltim | | (Ot-t F |
| | Пи оПЕ - | Yrs. Month | | Hours Min. | (Month, De | 1927 | 9. Birthple Country | ce (Stete or Foreign |
| 219-22-6914 Usual Residence of Decedent | X° 201 71 | | | | 1400 4 | 1321 | Mai | ryland |
| 10a. State 10b. County | 10c. Cit | ty, Town or Location | | | | | 100 | d. Inside City Limits |
| b MD Bolsie | | noenix | | | | | | 1 ☐ Yas 2 XNo |
| MD Baltin | nore ri | | | | | 011 // | | |
| 10e. Street and Number | In Dilea | 101. | Zip Code 211 | 2.1 | | 10g. Citizen of V | whet Country | y7 |
| 14006 Jarrettsvil | | | | | | USA | | |
| 11. Merital Status 1 Never Married 2 Merried | 12. Wes Decedent Ever in U Armed Forces? | ,S. 13. Wes De | cedent of H | lispanic Origin? (S an, Mexican, Puert | pecify Yes or No- o Rican, etc.) | | e - Americar ck, White, et | |
| | 1 XYes 2 No | 7 1□ Yes | 2√2 No | Specify: | | Specify | 1411 | |
| 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: 4 | | | | | Ороспу | | |
| 15. Decedent's E (Specify only highest gra | | 16a. Decedent's U | suel Occup | pation | rkina | 16b. Kind of Bu | usiness/Indu | istry |
| 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NO | T use retired | during most of word) | | | | |
| 4 | n/a | Mason | | | | Constr | uction |) |
| 17. Father's Name (First, Middle, Last |) | | | | ne (First, Middle, | | 18) | |
| Joseph Zimmern | nan, Sr. | | | Lilliar | Linder | non | | |
| 19a. Informent's Neme/Reletionship (| | 19b. Meiling Addr | ess (Street | and Number or Ru | ural Route Numbe | er, City or Town. | Stete, Zip C | Code) |
| Mary E. Zimmer | ** | | | ttsville F | | | | |
| 20a. Method of Disposition | 20b. F | Place of Disposition (/ | Vame of | | , Date | 20c. Location - | City or Tow | n, Siele |
| 1) Burial 2 ☐ Cremation 3 ☐ | | cemetery, cremetory of | | ce) 4/2 | 2/99° | | | |
| 4 Donation 5 Other (Specif | | plar Grov | | - | | n. Phoe | mix, | IVID |
| 21. Signature of Euperal Service HCS | nie) | | | uneral H | ome | | | |
| Michael J. Fl | agle | 10 W | . Pac | donia Rd | Timor | nium. M | D 210 | 93 |
| 23a. Pert 1. Enter the disease, or comshock, or heart failure. List only | plications that coused the deat | h. Do not enter the m | node of dyir | ng, such es cardie | or respiratory er | rest, | : 1 | Approximete nterval Between |
| aroon, or real clanule. List only | OTO COLUSO OTI SOCI IIIIO. | | | | | | | Onset end Death |
| Immediate Cause (Finel | Cardin | escular | 01 | 110010 | | | | 1900 |
| disease or condition resulting in death) | | or as e consequence | | sease | | | 1 | 1110 |
| | 15/500 | O 4 . M | 0 | | | | l k | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Freuer | es //W | -0. | | | | | |
| Sequentially list conditions, if any, leading to immediate | Due to (c | or as e consequence | | 1000 1 | | 4 | | |
| ceuse. Enter Underlying Cause (Disease or injury | c. Crebia | | | ressel | alsec | ule_ | i | |
| Cause (Disease or injury that initiated events resulting in death) Last | Due to (o | r as e consequence o | on): | | | | 1 | |
| | d | | | | | | 1 | |
| | | | | | | | 1 | |
| Part II. Other significant conditions of | contributing to death but not res | ulting in the underlyin | g cause giv | ven in Pert I. | 23b. Dld 1 | obacco use co | ntribute to t | the cause of death? |
| \$ | | | | | be | Yaa 2□ No | 3 Probe | bly 4 Unknown |
| | | | | | | | | |
| | | | | | 24a. Wes | en autopsy | 24b. Wer | a autopsy tindings lable prior to |
| Condition | | | | | peno | med? | com | pletion of cause |
| | | | | | | V. | | |
| | | | | | 101 | res 2X No | 10 | Yes 2 No |
| 25. Was case referred to medical examiner? | Hospital: | | 10 | | eth (Check only o | | | |
| 1 ☐ Yes 2 No | | | DOA | | lome 5 Resid | | er (Specify) | Scene |
| | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injui Woi | ry at | 28d. Describe | now injury occur | red | |
| 2 Accident investigation | n | M | | Yes 2 No | | | | |
| 3 Suicide 6 Could not b | 266. Place of injury - At h | ome, farm, street, fec | tory, office | | | Street and Numb | per or Rural | Route Number, |
| D TOMICOS | building, etc. (Specif | y/ | | | City or Tov | m, 31818) | | |
| | ysician: To the best of my kno | wledge, death occurr | ed at the tir | me, date and place | end due to the | cause(s) and me | enner as sta | ted. |
| 29a. Certifier Contifying Ph | niner: On the basis of examina and manner steted. | tion and/or investigat | ion, in my o | opinion, death occu | irred at the time, | dete and plece, | and due to t | he cause(s) |
| 29b. Signature and title of certifier | | 1 | 29c. Licens | se number | | 29d. Date signe | d (Month D | ev Year) |
| t and only against and or defined. | | | _ ~. LIGHT 15 | PO FIGHTINGS | | LJU. Date Signit | - ITTUITED, U | vr. ropr) |

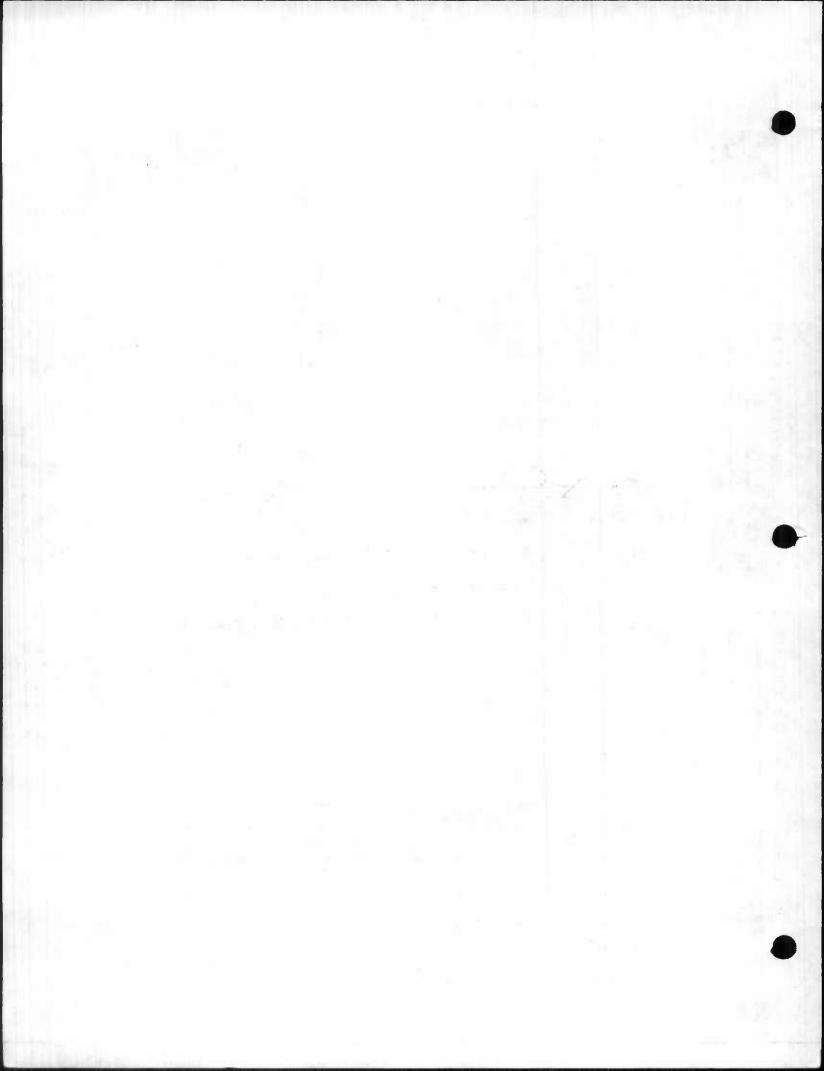
State Registrar

31. Date filed (Month, Day, Year)



7762

21204

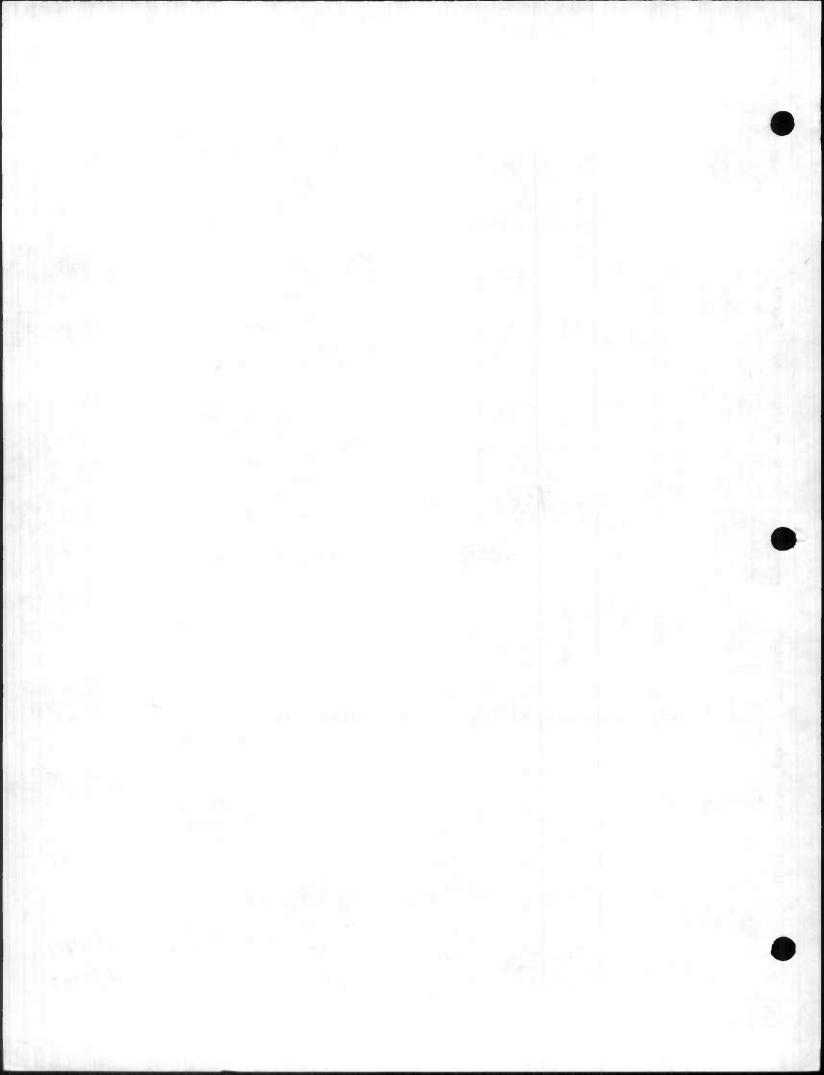


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State of Maryland / Department of Health and Mental Hygiene 9 1 2 3 9 8

| | | 1. Decedent's Nam | a (First stiddl- | I net) | | | | | of Death | 1 | 2. Data of Dea | leg. No. | | 3. Tima of Death |
|--|--|--|--|---|--|--|--|--|--|-------------------------|--|--|--|--|
| Physicia | _ | 1. Decedent's Nan | ia (FIFSI, MICOIA, | Lasi | | | | | | | Month | Day | Year | |
| /Medic | | 4a Facility Name (| | ZIENT | | | | | 4h City To | men or Lo | Apr 18 cation of Death | , 1999 4c. Count | | 08:00 AM |
| Examin | er | Ta Facility Hallio | ii iioi iiisiitoiioii, | give street and | number | | | | BALTII | | Ognori or Doda | | /A | |
| Funeral | | CHURCH_HOS | | 6. Sax | 7. Aga | (In yrs. last t | oirthday) | If Under 1 Y | ear If Under | | 8. Data of Birth (Month, Day | | • | place (State or Foreign |
| Funeral Director | | 215-05-7 Usual Rasidence of | 966 f Decedani | 1 M 2 N | | 85 | Yrs. | Months D | ays Hours | Min. | (Month, Day Jul5 , 191 | | Coul | |
| Maryland f ahow | | 10a. State | 10b. County | | | 10c. City, To | | | | 5 1 | | | 1 | 1 □ v 2 □ No |
| the notific | Director | MD 10e. Street and Nu | mber | | | BALTI | .MOR | 10f. Zip Co | de | | - | 0g. Citizen of | What Cou | ntry2 |
| ath with | oral D | 914 FELL | S STREE | | | | 1 | 2123 | | | | | | |
| 020 mg | by Fur | 11. Maritai Status 1 Never Mari | ried 2 Marrie | Armed | Decedent Ed Forcas? as 27 No. Giva or Datas: | | | Was Decedent If Yes, specify | | | city Yes or No- Rican, atc.) | Specil | ck, Whita, | |
| 72 ho | e d | /Sne | 15. Decedent's | | ed) | 16 | a. Dece | dent's Usual O | ccupation | at of worki | na | 16b. Kind of B | lusiness/In | dustry |
| within ene. | Completed | Elemantary/Seco | | 1 | e (1-4or 5- | +) | life. | DO NOT use re | etired) | t or works | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| and 212. be filed within that Hygiene. d other then | 00 | 6 | Afficia deletata e | | | | H | IOMEMAK | | | | HOME | | |
| yland 2121 build be filed within Mental Hygiene. arked other then ' etic event, the Me | m | 17. Fathar's Nama | | | | | | | MA | | (First, Middle, SUPERCZ) | | ne) | |
| aryla 2 should end Men a marke | 2 | THEODORE 19a. Informant's N | ZIENT/ | | | 15 | 9b. Meilir | na Address (St | | | Il Route Numbe | | . State. Zic | Code) |
| Magnith or treu | | HERBERT | ZIENT | | | | | | | | ALTIMOR | | | |
| Baltimore, Mar permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m eny Injury or other treum once. | - | 20a. Mathod of Dis | ☐ Cramation | | om Stata | cemei | lery, crei | osition (Name of matory or other LAUS CEMI | place) | | Data | 20c. Location | | |
| Baltin pemit. Ps Departmen important: eny Injury | | 21. Signatura of Fe | 5 ☐ Othar (Spenior Lineral Sarvice Li | - | | 31. 3. | | 2 Name and A | | 1. | r221999 | BAI | LTIMO | ORE , MD |
| Bange Permit | | 100 | | | | | | CACZOROW | SKI FUNE | | HOME | | | |
| Physician | | | art failura. List o | complications the | of caused in each line | tha daath. Do | o not ent | L201 DUN | dying, such as | cardiac o | | rest, | 1 1 | Approximata Intarval Batween Onset and Death |
| Physician /Medical Examiner | niner | shock, or hea Immediata Causa disaase or condition rasulting in death) | art failura. List o | a | an each line | tha daath. Do | o not ent | ter the mode of upence of): | dying, such as | cardiac o | or respiratory and | rest, | 1 1 | Intarval Batween |
| Physician /Medical Examiner bhysician and physician and ethe physician and the physician and the physician and | edical Examiner | shock, or hea | Art failura. List of (Final on onditions, onditions, or or or or or or or or or or or or or | b | on each line | Oua to (or as | o not ent | ter the mode of quence of): | dying, such as | cardiac o | or respiratory and | rest, | 1 1 | Intarval Batween Onset and Death |
| Physician /Medical Examiner physician and physician and ithe pnull-frensit the pnull-frensit | edical Examiner | shock, or head immediata Causa disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) | Art failura. List of (Final on onditions, nmadiata artying injury s Last | a | A cut | Dua to (or as a | a consequence | ter the mode of quence of): | dying, such as | cardiac | Tan Pa | nct 100 | 3 | Initaryal Batween Onset and Death |
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| MVISION Of VITAL RECORDS, P.O. BOX 68760, or Attending Physician: The law requires that the death certificate be associated by the death. More deat | Certification: To Be Completed by Physician/Medical Examiner | shock, or head immediate Causa disease or condition resulting in death) Sequentially list or if any, leading to in cause. Entar Und Cause (Disease or that initiated event resulting in death) Part II. Other significations of the causa avaniner? 1 Yes 2 2 7. Manner of Deat 1 Natural | (Final on onditions, madiata strying injury state to medical on onditions) | a. b. c. d. Hospital: 1 28a. Pland and be 28a. Pland | on each linit | Dua to (or as a due to (or a)))))))))))))))))))))))))))))))))))) | a consequence of the consequence | ter the mode of quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): | e given in Part 26. Plac Other: 4 N Injury at Work? 1 Yes 2 | t. e of Deathursing Ho | 23b. Did to 1 24a. Was a performance of Planck only on the Check on the Check | obacco use cover 2 100 obacco use cover 2 100 obacco use cover 2 100 obacco use cover 100 oba | ontribute t 3 Pro 24b. Way cc of | o the cause of death? This is a control of the cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? |
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| MVISION Of VITAL RECORDS, P.O. BOX 68760, or Attending Physician: The law requires that the death certificate be associated by the death. More deat | edical Certification: To Be Completed by Physician/Medical Examiner | shock, or heat shock, or heat disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) Part II. Other signification of the condition of th | Final on dilions, madiata oriying injury s Last ficant condition fired to medical or condition Could not datermine Could not | hospital: 1 Best on the best of the best | on each linu Cut Cut Cut Cut Cut Cut Cut C | Dua to (or as a superior of the control of the cont | a consequence of the consequence | ter the mode of th | e given in Part 26. Plac Other: 4 N Injury at Work? 1 Yes 2 | t. No | 23b. Did to 1 24a. Was a performa 5 Rasid 28d. Describe h | obacco use codes 2 No an autopsy med? as 2 No ane) ence 6 Ottoow injury occu | pontribute t 3 Pro 24b. Was confidence of firmed ber or Run enner as a and due t | o the cause of death? This is the cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? |
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death A-P 2 e redith Robert Zeigler 0200 AM 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Specialty Unit Medical olumbia Howava 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) Deys Hours 100 M 2□ F 212-42-6536 June 22,1943 Washington, DC Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Howard Co1umbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7146 Talisman Lane 21043 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify. White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 Medical Assistant Holy Cross Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Spruce A. Zeigler Miriam A. Zeigler 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Roland W. Zeigler (Brother) 10469 Willetts Crossing Rd., White Plains, MD 20695 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 04/19 Baltimore, MD 21. Signeture of Funeral Service Ligarises 22. Name and Address of Fecility Hardesty Funeral Home, P.A. alru 12 Ridgely Avenue, Annapolis, MD 21401 23e. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Betw ntra cranial He morrhage Immediete Ceuse (Finel 6 Weake diseese or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequenca of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No espiratory Failure 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

Completed

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Director

ò items 23a

traumatic event, the Macical Examiner must be notified at

"natural", or

Hygiene.

is marked other

Depertment of Haaith elimportant: If Item 27 is any injury or other traconce.

Peges 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0020

The law requires that the deeth certificate be executed signed by t d be detach has na 2 certificata or Attending Physician: this

P.O. Box 68760.

Records,

Division of Vital

10

Physician/Medicai þ Be Completed 2

Medicai Certification: After t s after death.

I Director: After the further of the part of the further of the f

1 Neturel 2 Accident 3 Suicide 4 Homicide

29a. Certifier

6 Could not be

5 Pending investigation

Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Tyes

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year)

| Sarygy | V. Shah | MD |
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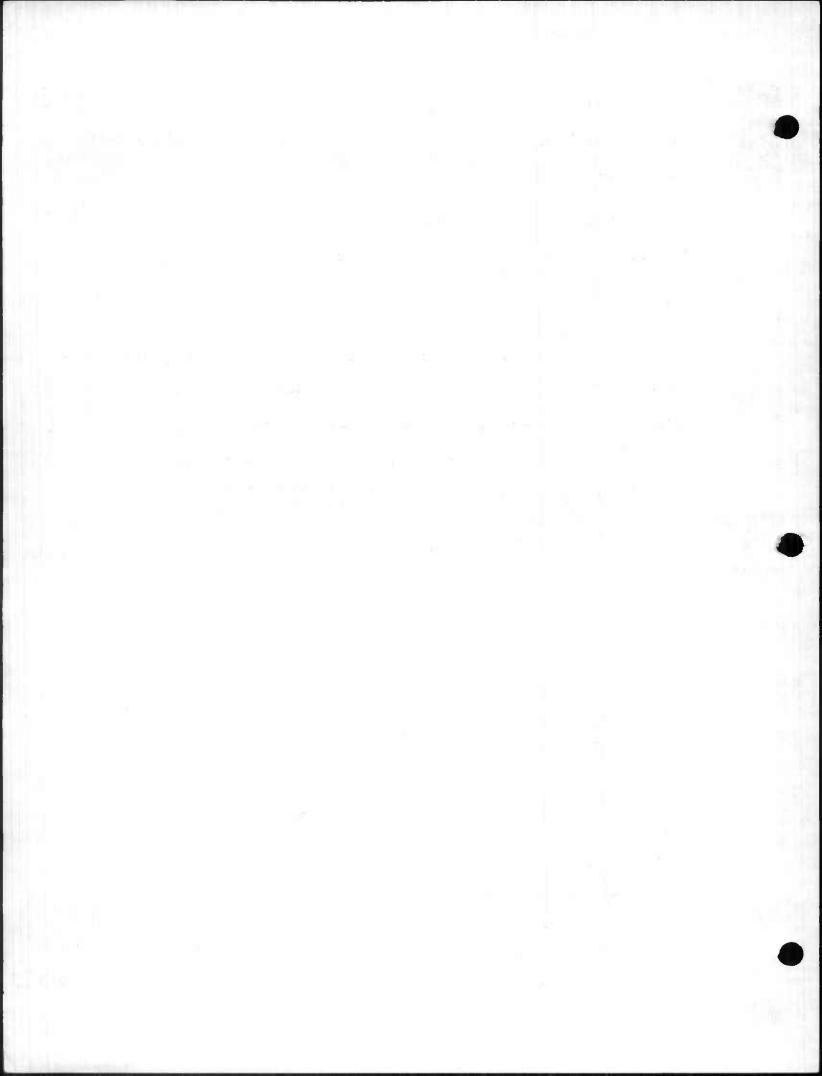
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

10805 Hickory Ridge nd #210, Columbia, MD210 SHAH, MD SANTAY 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

APR 2 3 1999

To the Hospital or A within 24 hours after To the Funeral Direc complately filled in by



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth 3 Time of Death Month HELEN BRITTINGHAM BUNDICK 99 9:15 AM 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death POCOMOKE WORCESTER COUNTY HARTLEY HALL NURSING HOME If Under 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax Birthpleca (Stata or Foraign Country) 8. Date of Birth (Month, Day, Yaar) 1□ M 200 F Months Days Hours 88 231-42-8484 VIRGINIA 9 10 10 Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No POCOMOKE CITY WORCESTER 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 1006 MARKET ST 21851 USA 12. Was Dacadant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Bleck, Whita, atc. 1 Naver Marriad 2 Married 1 ☐ Yas 2 ☒ No Spacity: Specify: 3 ₩ Widowed 4 Divorcad WHITE 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) RETAIL PHARMACY CLERK 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) BRITTINGHAM JOHN MOORE HANNAH 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SON A.T. BUNDICK 179 EMILY DR., SALISBURY, MD 21804 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete cematary, crematory or othar placa) 1 M Burial 2 □ Cramation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) WESSELLS CEMETERY MEARS, VA 4/5/99 21. Signature of Funeral Sarvica Licensee 22. Nama and Address of Fecility WILLIAMS-PARKSLEY FUNERAL HOME, INC. 25046 PARKSLEY RD., PARKSLEY, VA 27 or haart fallure. List only one cause on each line. arterioselerotie Cardiovascula Disease Immediata Cause (Final disaase or condition rasulting in daath) Dua to (or as e consequança of): Dua to (or es a consequance of) Part II. Other significant condition 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown levance 24a. Was an autopsy

Physician /Medical Examiner

attending physician and for use as the bunal-transit

signed by t

page 2 :

certificete

this

within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral

The law requires that the death certificate be executed

Box 68760

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Records,

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Division

Hospital or Attending Physician:

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Director

r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at

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Pages 1 and 2 should be filed within 72 hours aftar

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permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygians Important: If item 27 is marked other that any injury or other traumatic aware

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediata cause. Entar Undarlying Cause (Diseesa or Injury that initiated events resulting in daath) Last

25. Wes casa rafarrad to medical axaminar?

29b. Signeture and titla of certifiar

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5 Panding invastigation

6 Could not be datarmined

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27. Mennar of Death

1 Neturel

2 Accidant

3 Suicida

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(Check only one)

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| 7/1 | | 3. | - 0 | 1 | 1". |

1 Inpatiant 2 ER/Outpatient 3 DOA

Plece of injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28b. Tima of

28e. Data of Injury (Month, Day Year)

Delles

24b. Wara autopsy findings available prior to complation of causa of deeth?

1 Yas 2 No

1 Yes 2 No

26. Plece of Deeth (Check only ona)

Othar: 4. Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

28c. Injury et Work? 28d. Dascribe how Injury occurred

1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Physicien: To the bast of my knowledge, death occurred et the tima, deta and placa, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the bast of examination and/or invastigation, in my opinion, death occurred et tha tima, data and place, end dua to the cause(s) end mennar stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

M. Nama and addrass of person who completed cause of death (Itam 23e) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Data filad (Month, Day, Yaar)

State Registrar

32. Registrar's Signature Deneros



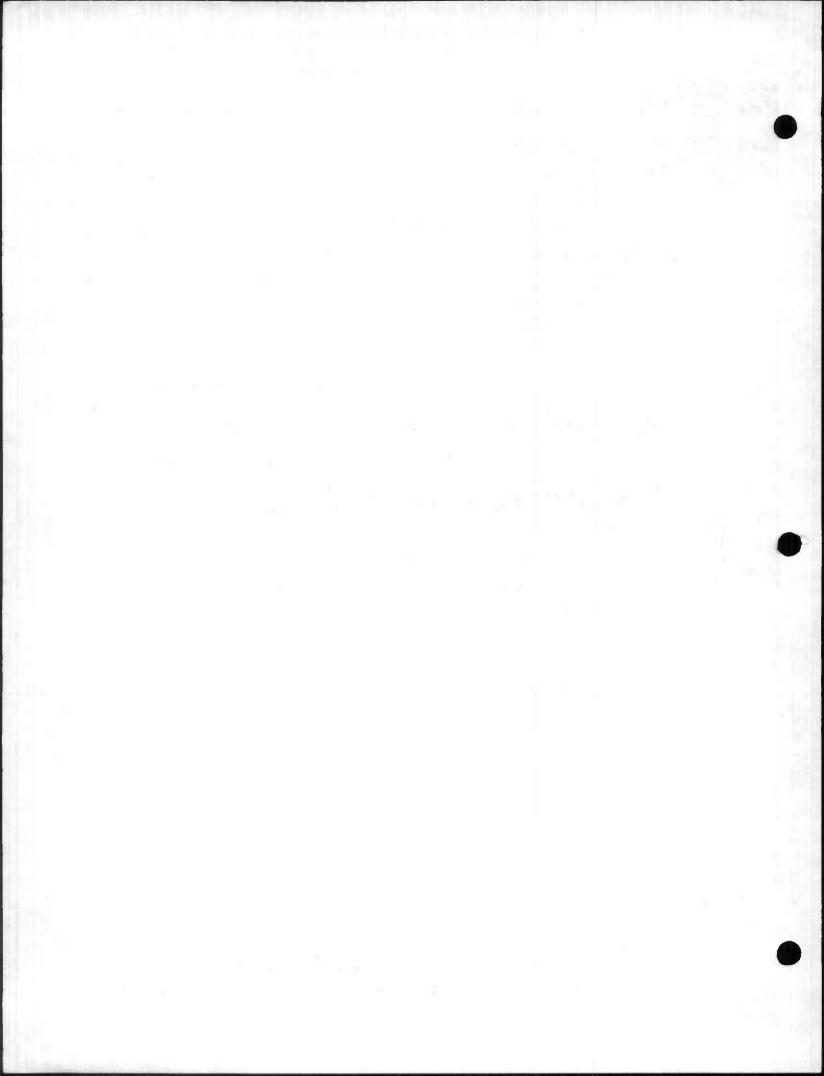
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State of Maryland / Department of Health and Mental Hygiene

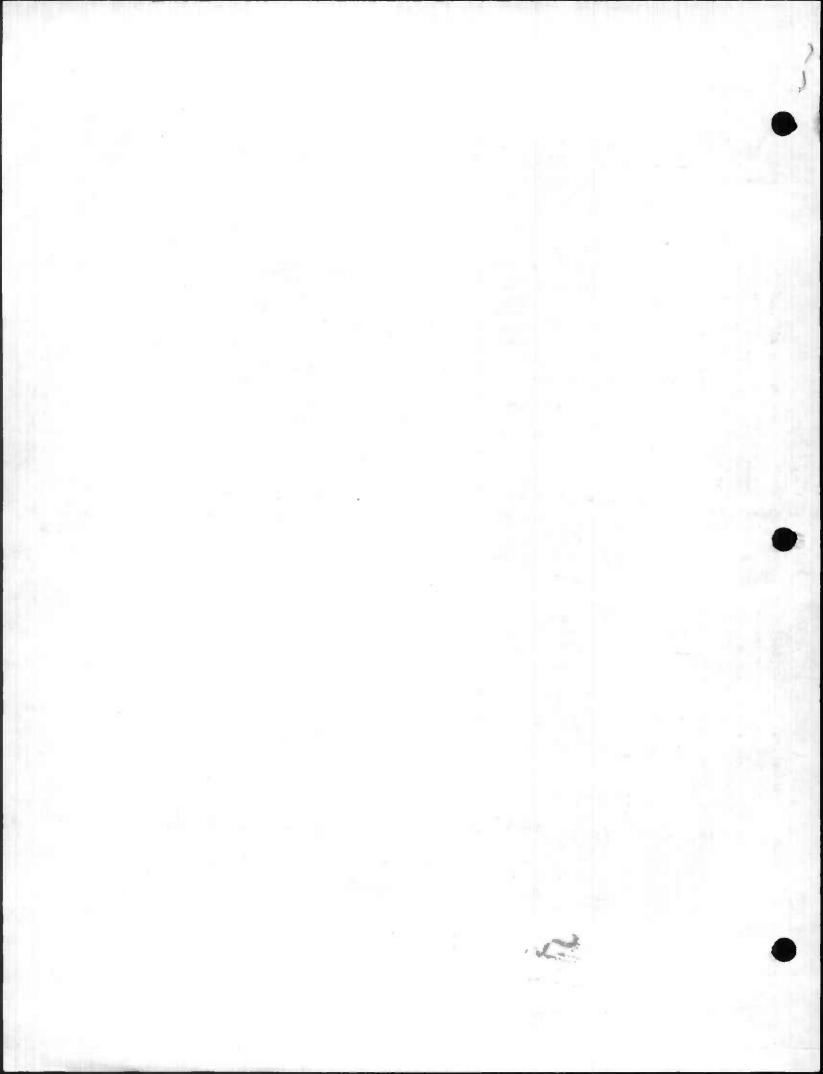
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| | | | | | Certin | ficate of | Death | | Reg. No. | | | |
|---|------------------|--|---|---------------------------|-----------------------|--|--|---------------------------------------|---------------------------------------|--------------------------------------|---|----------------|
| D I 11 | | 1. Decedant's Name (First, Middle, La | st) | | | | <u> </u> | 2. Data of Dec | ath | Vana | 3. Tima of | Deeth |
| Physic /Med | | RICHARD GREGO | RY BOWIE | | | | | April | Day 13 | 1999 | 3:12 | 2pm |
| Exami | | 4a. Fecility Nama (If not institution, giv | re street and number) | | | | 4b. City, Town, or | | | y of Death | | |
| | | CIVISTA MEDICAL | CENTER | | | | LA PLAT | ΓΑ | CHA | RLES | | |
| Funera Director | | | 7. Age (In yrs | . last birtho | N | f Undar 1 Yaa fonths Dey: | Hours _Min. | | 7,1959 | 9. Birthp Coun Mar | olace (State o otry) yland | or Foreig d |
| a w | | Usual Rasidanca of Decedent 10a. Steta 10b. County | 10c. C | ity, Town o | or Locati | ion | | _ | | 1 | 0d. insida Ci | ity Limifs |
| the Mery 28a-f eho | ector | MD Char | les W | elco | | 104 7in Code | | | 40 Oliver of | | 1 ☐ Yes | |
| ath with | Funeral Director | 6390 Firetower | Road | | | 2069 | | | 10g. Citizan of USA | | | |
| should be filed within 72 hours after death with the Menyland all Mental Hygiene. marked other than "natural", or items 23s or 28s-f show implic event, the Medical Examination and the holling at | þ | 11. Maritel Status 1 Nevar Married 2 Married 3 Widowad 4 Divorced | 12. Wes Decedant Evar in I Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: | J,S. | | s Decedent of es, specify Cu Yas 2X No | Hispenic Origin? (Sban, Mexican, Puerlo) Specify: | specify Yas or No- to Rican, etc.) | Ble | ce - Amaric ck, White, fy: Whi | etc. | |
| 72 h | Completed | 15. Decedent's Ed (Specify only highest gra | ducation ade completed) | 18a. D | ecedani Give kin | t's Usual Occi | pation during most of wo | rkina | 16b. Kind of B | usinass/inc | dustry | |
| Althin | npl | Elementary/Secondary (0-12) | Collega (1-4or 5+) | | | | e during most of wo | 9 | | | | |
| filed with Hygiene ther the | | 9 | | | Sto | re Cl | 1 | | Groce | | | |
| 0 = 0 5 | Be C | 17. Fether's Nema (First, Middle, Last) James Bowie |) | | | | Hazel N | ma (First, Middle, Margare | | , | wie | |
| mark mati | To | 19a. informent's Name/Ralationship (| Type Print) | 19h M | Aailing A | Address (Stree | et and Number or Ri | | | - | | |
| lth ar | | Hazel M. Bowie | | | | | | | | , olulo, Ep | 0000) | |
| Hee Hee | | 20e. Method of Disposition | 20b. | Placa of D | ispositio | on (Name of ory or other pi | Welcome | Data | 20c. Location | - City or To | own, Stata | |
| Pege ento nt: If | | 1 N Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Specification) | Ramoval from Stata | | | | al Gar. | 1/17/99 | Waldo | orf.M | TD. | |
| permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev any Injury or other traumatic ev | | 21. Signature of Funaral Sarvica Licer | | | 22. N | eme end Add | rass of Facility | | | | | |
| 00540 | | Tovid (| - Ecles M | 00915 | P_O | ROX | ECHOLS I | PLATA | $\frac{\text{HOME}}{\text{MD}} = 206$ | | | |
| | | 23a. Pert1. Entar tha disaasa, or com shock, or haart fallura. List only | plications that caused tha dae one cause on each line. | th. Do not | t antar t | ha moda of dy | ring, such as cardia | or raspiratory ar | rast, | , , | Approximete interval Bat | ween |
| Physician /Medical | | Immediate Course (Final | | | | | | | | i I | Onsat and I | Death |
| Examiner | | Immediate Ceusa (Final disaasa or condition rasuiting in death) | a. Asphyxia Se | conda | ary | to for | eign | | | | | |
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| uted | Examiner | | b. body (meat | | | 1 | way inlet | | | <u> </u> | | |
| an and | | Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying | Dua to | or as a cor | nsequar | nca of): | | | | 1 | | |
| eath certificate be executed ettending physician and for use as the burial-transit | edicai | Causa (Diseasa or injury thet initiated events resulting in daath) Last | C. Due fo (| or as a cor | nsequar | nca of): | | | | | | |
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| net the death d by the ette | Physician/ | Pert II. Other significant conditions of | ontributing to death but not ra | sulting In th | ha unda | rrying causa g | ivan in Part I. | 23b. Dld 1 | obacco usa co | ontribute to | the cause | of death |
| thet the death ned by the etter e deteched for | by Phy | | | | | | | 10 | Yes 2□ No | 3 Prot | bably 4 🖾 | Unknov |
| The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit | Completed | | | | | | | | en autopsy med? | eve co | ara autopsy f eileble prior t mplation of c daath? | to |
| | Sol | | | | | | | 101 | as 20 No | 10 | Yas 21 | No |
| ysician: The is certificate director, peg | Be | 25. Was casa rafarrad to medical axaminar? | | | | | | ath (Check only o | ne) | | | |
| 0 0 | 2 | 1 Yas 2 No | | ER/Outpo | | JU DON | | fome 5 ☐ Rasio | | | y) | |
| th. After a funer | tion | 27. Mannar of Death 1 ☐ Naturel 5 ☐ Panding 2 ☐ Accident Invastigation | 28a. Data of Injury (Month, Day Year) | 28b. Tim Inju | ıry | 28c. Inj W M 1[| uryat ork? ⊒Yas 2 ⊒ No | 28d. Dascribe I | ow injury occu | rred | | |
| To the Mospital or Attending Physician: The Within 24 hours effer deeth. To the Funeral Director: Affer this certificat completely filled in by the funeral director, pt | Certification: | 3 Suicide 6 Could not be determined | 28a. Placa of Injury - At I building, etc. (Spec | noma, farm | ı, straat, | , factory, office | 1 | 28f. Location (S City or Tox | | ber or Rura | I Route Num | ıber, |
| Hospita 24 hours Funeral etely fille | edical C | 29e. Cartifiar 1 Certifying Ph (Check only one) | ysician: To the best of my kn ninar: On tha basis of axamin and manner stated. | owledge, d ation and/o | laeth oc or Invest | ccurred at the tigetion, in my | time, dete end plece opinion, death occu | e, and dua to the curred et tha tima, | cause(s) and m data and place, | enner as st | leted. the cause(s | 3) |
| omple | Me | 29b. Signature and titla of cartifiar | and marries states. | | | 29c. Licar | nsa number | | 29d. Data signe | ed (Month, | Day, Year) | |
| F > F 0 | | yahin u. | Tayouri us. | 0 | | D | 50000 | | 4-14 | -11 | | |
| | | 30. Name and addrass of person who | | | /De. Prir | | 50883 | | | | | |
| | | Yahia M. Tagouri | | | | | - | | | _ | in | |
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| Regist | rar | APR 1 5 19 | 99 Janes | 1 | 1. | BOOLA | 1 | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item #5, Per F.D. State of Maryland / Department of Health and Mental Hygiene 4/9/99, Carroll County, wjl Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Harold Winford Bowles Sr. HUM 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUS Count Gen an al Carroll Carroll Westminster 1 Year | If Under 24 Hrs. | 8. Date of Birth Days | Hours | Min. | March | 7 H Under 9. Birthplace (State or Foreign Country)
Va. **Funeral** Months 1(XM 2□ F 226-26-8293 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show must be notified at Carroll Sykesville Md Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Grandview Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1946— 1 Tyres 2 □ No If Yes, Give 1955 Year or Datas: Home Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, Whita, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 ò. 1 Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) meat cutter food service 10 Baltimore, Maryland th end Mentel Hy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Neal Bowles Lucy Mae Saunders Pages 1 and 2 should nent of Health end Men 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health e Mrs. Emma Bowles (wife) 1010 Grandview Ave., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 6 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny Injury or pace. 4 Donation 5 NOther (Specify)entombment Evergreen Mausoleum 4-12-99 Finksburg, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Buan P.O. Box 195 Sykesville, Md 21784 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner mort Itsan Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Vulmunur. Obstructive 24a. Wes an autopsy 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Naturei 2 Accident 5 Panding investigation To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al 1 Yes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause ot death (Item 23a) (Type, Print) West minsty, mamorial BUAIT 200 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o Certificate of Death

| | | | | Ce | unicale | UID | ealli | | | Reg. No. | | |
|---|--|---------------------------------------|--------------------------------|----------------------|---|----------------|------------------------------------|------------------------|--|-----------------------------|--------------|--|
| Physician /Medical | 1. Decedant's Nama (First, Midd Hannah Baile | | | | | | | 4 | 2. Date of Do Month | Dey | Yaer 1999 | 3. Time of Death |
| Examiner | 4a Facility Neme (If not institution WICOMICO NUF | | | | | | City, Tow | | ation of Dear | th 4c. Count | y of Deeth | |
| Funeral Director | 5. Social Security Number 213-10-8360 Usuel Residence of Decedent | 6. Sex 1 □ M 2 🔀 F | 7. Age (In yrs. la: 94 | st birthday) Yrs. | If Under 1 Y Months D | eer I | f Under 24 Hours | 4 Hrs. 8 | B. Date of Bi (Month, D | | 9. Births | place (State or Foreign ontry) 1 and |
| with the Maryland Le or 28a-f show Le notified at | 10a. State 10b. County | | | Town or Lo | | Т | | | | | 1 | 1 Od. Inside City Limits |
| n the Marylan r 28a-1 show notified at | MD Wic | omico | Sal | isbur | y 10f. Zip Co | de | | | | 10g. Citizen of | What Cou | |
| 23a or | 845 Johnson Ro | ad | | | 2180 | | | | | USA | | |
| filed within 72 hours after death with the Mai Hygiene. Hygiene That are the same 23a or 28a-f s not, the Medical Examener must be notified or Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Met 3 StWidowed 4 Divorced | rried 1 ☐ Yes | 2⊠ No iiva | | Wes Decedent If Yes, specify 1 ☐ Yes 2123 | | anic Origi Maxican, Specify: | in? (Spec Puerto Ri | ify Yes or N ican, etc.) | 0- 14. Ra Ble Specia | ock, White, | can Indian, etc. lite |
| be filed within 72 hours tal Hygiene. d other than "naturef", avent, the Medical Ex- event, the Medical Ex- Be Completed by | 15. Deceder (Specify only highe | nt's Education est grade completed |) | (Give | dant's Usuel O kind of work d | one dur | on ing most o | of working | 7 | 16b. Kind of B | usiness/In | dustry |
| than the Me | Elementery/Secondery (0-12) | College | (1-4or 5+) | | <i>DO NOT</i> use <i>n</i> emaker | etirea) | | | | Hot | me | |
| marked other matic event, tr To Be Co | 17. Fether's Neme (First, Middle, | , Last) | | | | 11 | 8. Mother | 's Neme (| First, Middle | a, Maiden Suma | ma) | |
| 7 is marked of traumatic every To Be | Herman Howard | | | | | | | | | Howard ber, City or Town | | |
| of Heali f Rem 2 r other | Meta Joyce Ma 20e. Method of Disposition 1 1 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (3 | 3 Removel from | 20b. Pla cer | netery, cre | Johnsor osition (Name of matory or other hens Ce | of r place) | | | bury, Data | MD 213 | - 30 | |
| Important: It sny injury o | 21. Signatura of Funarel Sarvice | Licensea att Han | | 2: | Short E | ddress | of Fecility | Home | elmar, | | 940 | |
| cian and particular purish transit purish transit purish transit al Examiner | 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Ceuse (Finel disease or condition resulting in deeth) | | Due to (or | ereli es e conse | e Caraquence of): | | | | | | 1 | Approximate Intervel Between Onset and Death |
| nding physuse as the | Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated evants resulting in death) Last | d | Due to (or e | es e consec | juence of); | | | | | | | |
| artificate has been signed by the attenctor, page 2 should be detached for Be Completed by Physicia | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Organic Brain Syndrome | | | | | | | | | | | o the cause of death bably 4 Unknow |
| as been signed by the atte s 2 should be detached for npleted by Physicia | Essent | ral ? | Hype | rte | uses | 2 | | | 24e. We | s an autopsy formed? | 81 | Vera autopsy findings vallabla prior to ompletion of cause death? |
| r, page | anen | na | | | | | | | 10 | Yes 2 No | 1 | Yes 25 No |
| dire dire | 25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No | Hospitel: 1 | | R/Outpetie | | Other: | 4 M Nur | sing Hom | | sidance 6 🗆 Ot | | fy) |
| or: After the funere cation: | 3 Suicide 6 □ Could | not be | e of Injury onth, Day Year) | 28b. Time of Injury | М | | t s 2 N | lo | 28d. Describe how injury occurred 28l. Location (Streat and Number or Rural Route Number, | | | |
| 44 hours after death. Funeral Director: After taly filled in by the fune sical Certification | 4 ☐ Homicide determ | nined 200. Flou | ding, etc. (Specify) | ,o, ienii, Si | oot, lactory, of | | | 20 | City or To | own, Stata) | .so. or riar | |
| To the Funeral Directory filled in the Medical Certi | (Check only 2 Medical one) | | | | vestigetion, in | my opin | ion, death | | | , data and place | , and dua t | o tha causa(s) |
| within To the compla | 29b. Signature end litie of certific | who completed cau | Bell | 202 | 29c. Li | cansa r | 95 | 05 | | 29d. Data sign | ed (Month, | |

State Registrar

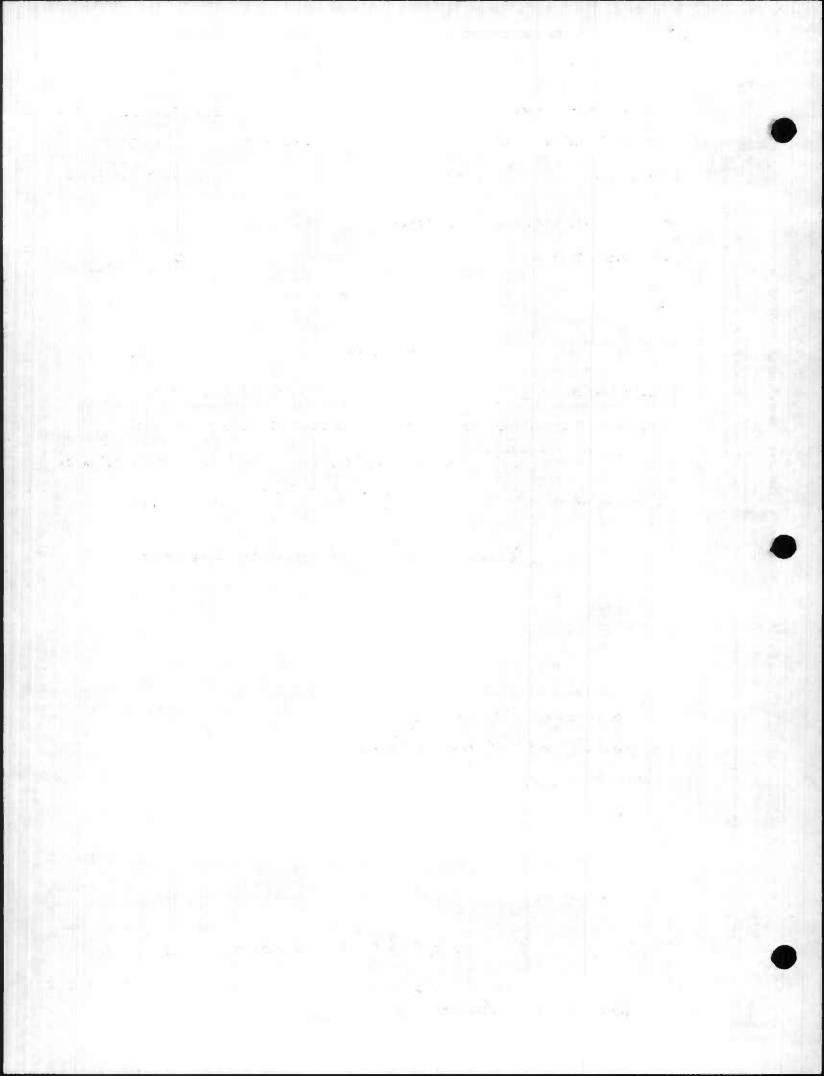
GREGORIO M. BELLOSO, M.D., 3502 CHINABERRY DRIVE, SALISBURY, MD 21801

31. Dete filed (Month Day Year)

APR 0 8 1999

32. Redistrer's Signeture

Aparllo



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Yee Barkley - Bishop Beverly 17:41 1999 APRIL 6 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) THE John'S 5. Sociel Security Number BA/timore if Under 24 Hrs. Hours Min. HOPKINS CIty If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 7. A.m. (In yrs. lest birthdey) 1□M 250 F Months Deys 213-90-9891 Oct 10, 1966 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Ferndale Road 21801 U.S. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 Merried Specify: black 1 Yes 2 No Specify: 3 □ Wirdowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) store manager retail 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles B. Barkley Cynthia A. Jones 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3850 Barkley Rd., Eden, MD 21822 Cynthia A. Barkley/mother 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) 4/10/99 Green Acres Mem Park Salisbury, MD 21. Signeture of Funeral Septice 22. Neme end Address of Fecility Lewis N. Watson Funeral Home 23a. Pert1. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one couse on each line. Approximete Interval Between Onset end Deeth tmmediete Ceuse (Finei diseese or condition resulting in deeth) Scudomal SCASIS ZWECKS Due to (or es e consequende of): Neutropenia Due to (of es e consequence of): manth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Acquired Immuno deficience Pert tt. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the ceues of death? 1 Yae 2 10 3 Probably 4 Unknown Aspergillus intection

Examiner attending physician and for usa as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the a by should Completed cartificate has b director, page 2 s Be Certification: To this funaral Aftar within 24 hours after death To the Funeral Diractor: , complately filled in by the

edicai

29b. Signeture and title of certifie

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

the Manyland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Itema 23a or 2 any highry or other traumatic event, the Head call Examinest must be an other.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

| | | | 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? |
|---|--|------------------------------|---|--|
| | | | 1□Yes 2□No | 1 ☐ Yes 2년 No |
| 25. Wes cese referred to medical | | 26. Plece of Deeth | (Check only one) | |
| examiner? 1 Yes 2 No | Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA | Other: 4 Nursing Hom | e 5 Residence 6 Oth | er (Specify) |
| 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation | (Month, Dey Year) Injury | : Injury at Work? 1 Yes 2 No | 8d. Describe how Injury occur | red |
| 3 Suicide 6 Could not be determined | | office 2 | 8f. Location (Street end Numb City or Town, Stete) | er or Rural Route Number, |
| | yelclan: To the best of my knowledge, death occurred at niner: On the bests of examinetion end/or investigation, in end menner stated. | | | |

3 State

Registrar

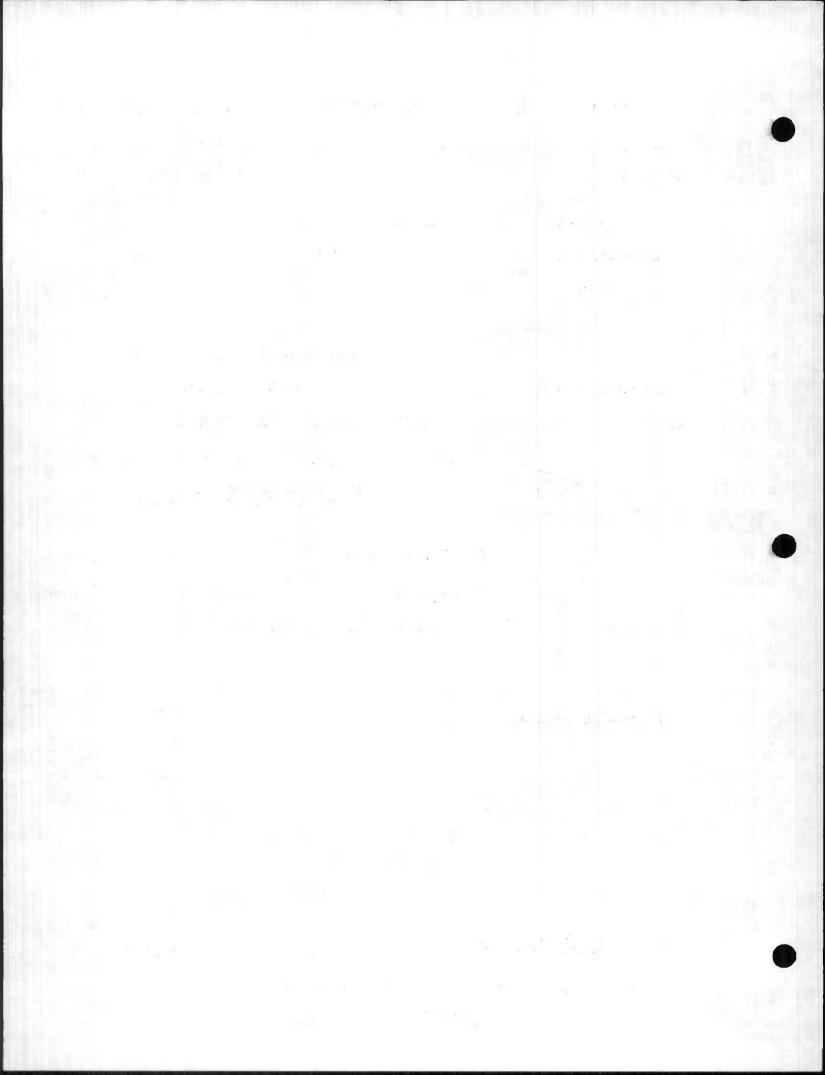
Recident

29c. License number 29d. Dete signed (Month, Dey, Year) 4/6/49 REG-000

30. Name end address duperson who completed cause of deeth (Item 23e) (Type, Print)

Sinivasan TOWE (1)

31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture APR 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 03 BERNARD **Physician** 14:49 COLEMAN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Atlantic General Hospital Berlin If Under 24 Hrs Worcester If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Deys Hours 1X M 2□ F Months 578-48-6598 64 Director Jan 29, 1935 Dist. of Colum Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inalde City Limits r 28a-f ahow 1 Yes 25 No Directo MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ms 23a or 8840 Lewis Road 21811 U.S. Funeral iral', or items ? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. 11. Maritei Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1K Never Married 2 ☐ Married Maryland 21215-0020 specify: black 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementery/Secondary (0-12) College (1-4or 5+) Laborer 12 Restaurant Pages 1 and 2 should be filed nant of Health and Mental Hygi-int: if item 27 is marked other 17. Father'a Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Be unknown Ruby Irene Dickerson 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 56591 Dallas Place Apt. 12, Temple Hill, MD 20748 Florence Anderson/sister Baltimore, 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department if 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 4/3/99 Berlin, MD 21. Signature of Euneral Service License 22. Name end Address of Fecility Lewis N. Watson Funeral Home 23a. Pert1. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) MYO CARDIAL EW MYS Examiner Due to (or as a consequence of): Examiner 0 TEW MONTHS physician end the burial-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence of): certificata be Physician/Medicai Due to (or as e consequence of) 80 USB Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ♣ Unknown þ 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funaral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 ☐ Inpatient → ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident sfter deat 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of tnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1 06241 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 203 SNOW ST. SNOW HILL, NO. 21863 WZOTK INDRTH 31. Date filed (Month, Day, Year) 32. Registrer's Signature

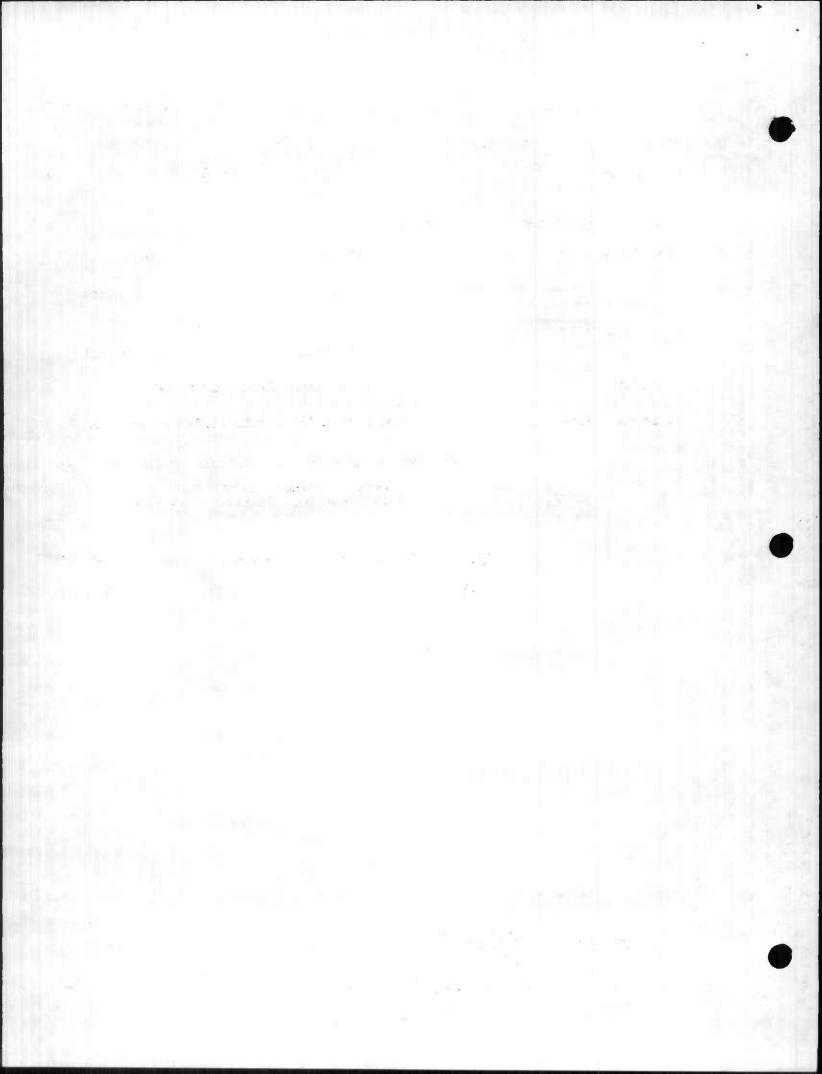
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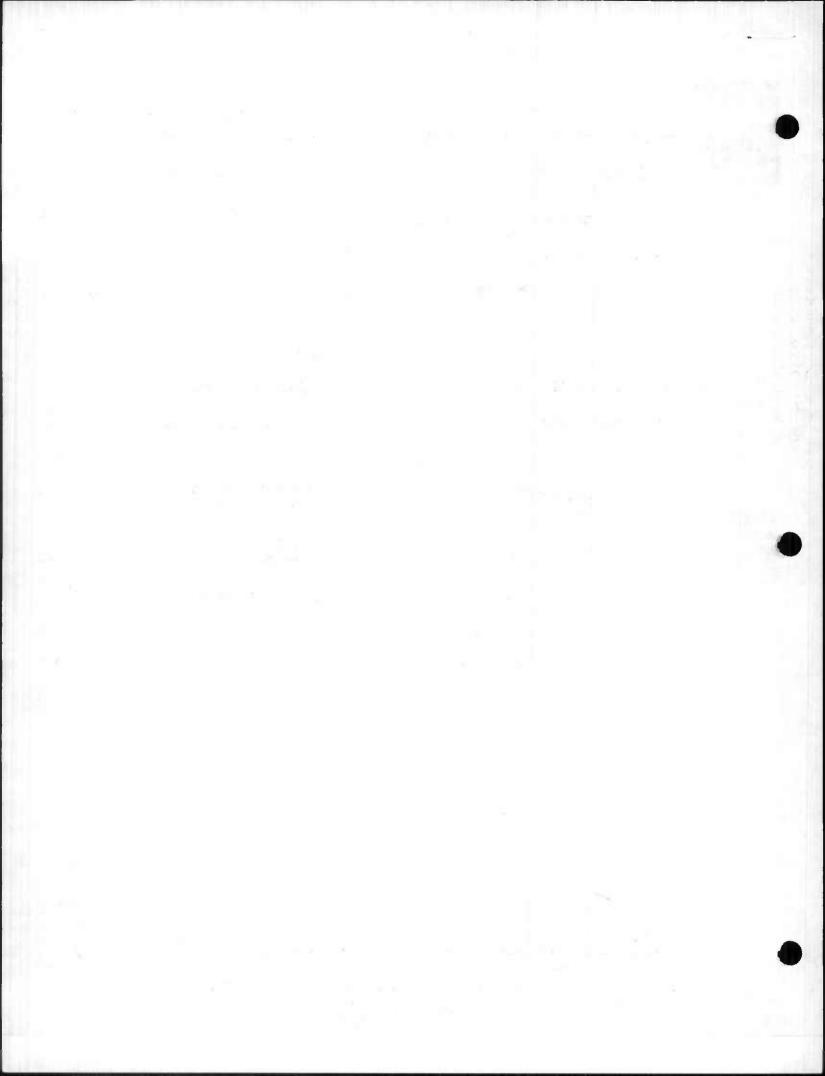


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jrd State of Maryland / Department of Health a Amended item 12 per F.H. 4/5/1999 Certificate of Death State of Maryland / Department of Health and Mental Hygiene O 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** George W. Carroll, Jr. 4b. City, Town, or Location of Death 4c. County of Deat 0531 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner SALISBURY PENNINSULA REGIONAL MEDICAL CENTER Hours Min. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 54 Yrs. Director 214-42-7940 Jan 2, 1945 MD Usual Rasidance of Dacedant 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 XNo Director MD Wicomico Salisbury 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ð 700 Edgewater Dr. Items 23s 21801 U.S. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Yas Broot If Yas, Giva Yaar or Datas: 14. Raca - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) "netural", or Item edical Examiner. 1 Navar Married 28 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: black þ 3 Widowed 4 Divorced Completed the Medical 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) nd Mental Hygiene. marked other than Elamantary/Secondary (0-12) Collaga (1-4or 5+) supervisor nylon 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be Health and Mental George W. Carroll, Sr. Elizabeth Purnell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) mportant: If item 27 is: any injury or other treu Sylvia Carroll/wife 700 Edgewater Dr., Apt. 203, Salisbury, MD 21801 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 4/3/99 Salisbury Crematory Salisbury, MD 21801 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 25a. Part 1. Enfor the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaen Onsat and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner 71 mula ty ty the man consequence of) The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last Box 68760 ding physician 251 Physiclan/Medical Dua to (or as a consequance of): 11 to Rua From P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of ceuse Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was cesa rafarred to madicel axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding invastigation 1 DNatural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not ba datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Cartifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 3-30-89 30. Nama and addrass of person omplated ceusa of daath (Itam 23a) (Type, Print) 201 APR 02 1999 31. Data filed (Month) 32. Registrar's Signatura State Registrar



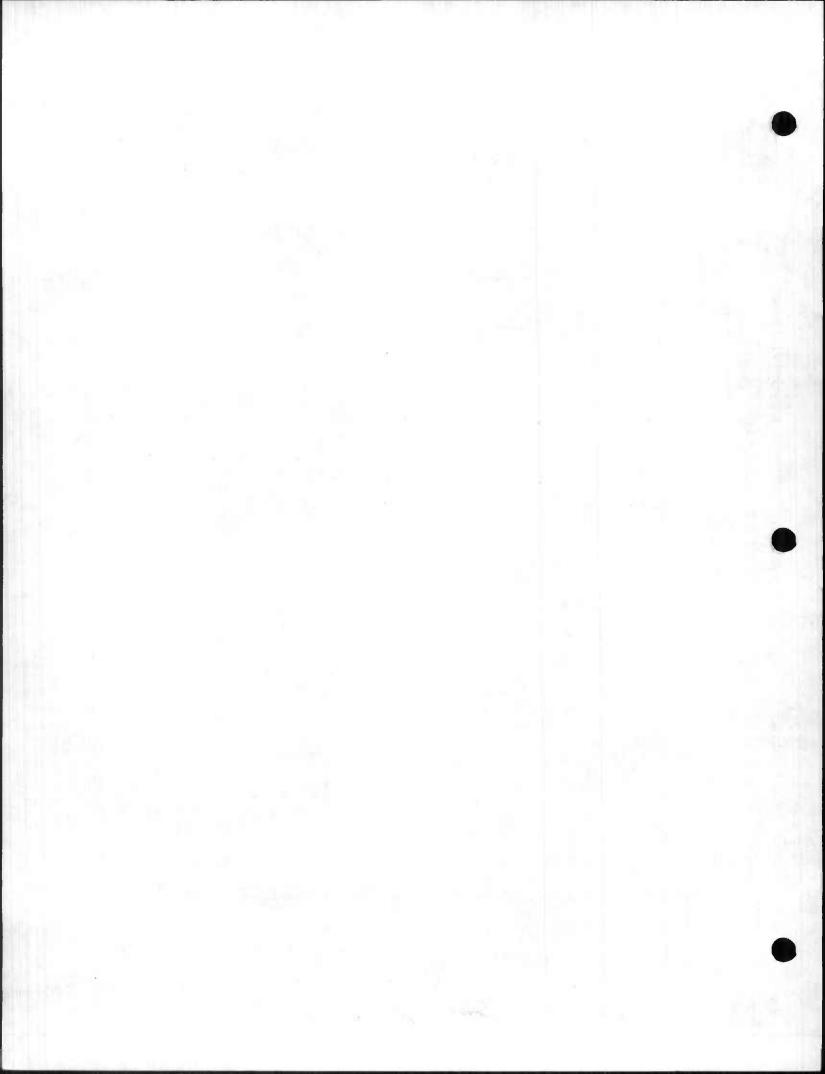
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Elsie 3, C. Chatham April 1999 5:50 AM /Medical 4a Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Salisbury Center: Genesis ElderCare Salisbury, Wicomico MD 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country)
 DE • **Funeral** Months Days 1 □ M 2 🗓 F Hours 221-14-0943 Director 74 Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Salisbury Wicomico the 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò 234 200 Civic Ave. 21801 USA Funeral death Herrs 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. filed within 72 hours after of Hyglene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Convenient Market Store owner 12 marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 end 2 should be file Department of Health and Mentel Hy Important: if Nam 27 Is marked oths any Injury or other traumatic avent once. Be Walter Hastings Myrtle Hastings Hastings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20350 Nanticoke Rd. Nanticoke, Md. Ed Biscoe, Grandson 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removal from State Springhill Memory Gardens 4-6-99 Hebron, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home, Inc. 21. Signature of Funeral Service Licenses 13 E Grove St. Delmar, De. 19940 leans 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each light Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): 80 for Use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by requires 24b. Were eutopsy tindings svailable prior to 24a. Was an autopsy performed? completion of cause of death? The lew 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 1 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Many er of Death 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the f deeth. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifies 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villiam H. Robins M.D Dr. Salisbury Hhwai 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State

DHMH 16 Ray 6/95

Registrar

APR 06



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle I ast) 2. Date of Deeth Month Vear LOUISE LONG CAREY 4b. City, Town, or Location of Death 1999 fes 4c. County of Death 4a. Facility Name (If not institution, give street end number) SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 1□M 2K)F Deys Yrs. 220-10-8312 JAN. 11,1915 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 808 PARKER RD. 21804 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5 SEAMSTRESS SHIRT FACTORY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) JOHN TURNER SUSAN BRAMBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LOIS TAGLIALAVORE - DAUGHTER 808 PARKER RD. SALISBURY, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State PARSONS CEMETERY 4/9/99 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY, MARYLAND 22. Name and Address of Facility 705 E. MAIN ST. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. SALISBURY, MD 21804 Approximate Intervat Between Onset and Deat Immediate Cause (Final < 24hvs disease or condition resulting in death) Asystole cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) ASHD Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete)

Physician /Medical Examine

that the death certificate be axecuted

Box 68760,

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours afterent of Health and Mental Hygiene. Oft: If Item 27 is marked other than "natural", or F

Department of Health important: if item 27 i

Maryland 21215-0020

Baltimore,

Secure !

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and physician a s the burial-I the attending for use as ed by the detached signed by t page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Examiner Physician/Medical Completed 2 Certification:

þ

edicai

29a. Certifier 29b. Signature and title of certifier

4 ☐ Homleide

1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

SALISBUTY,

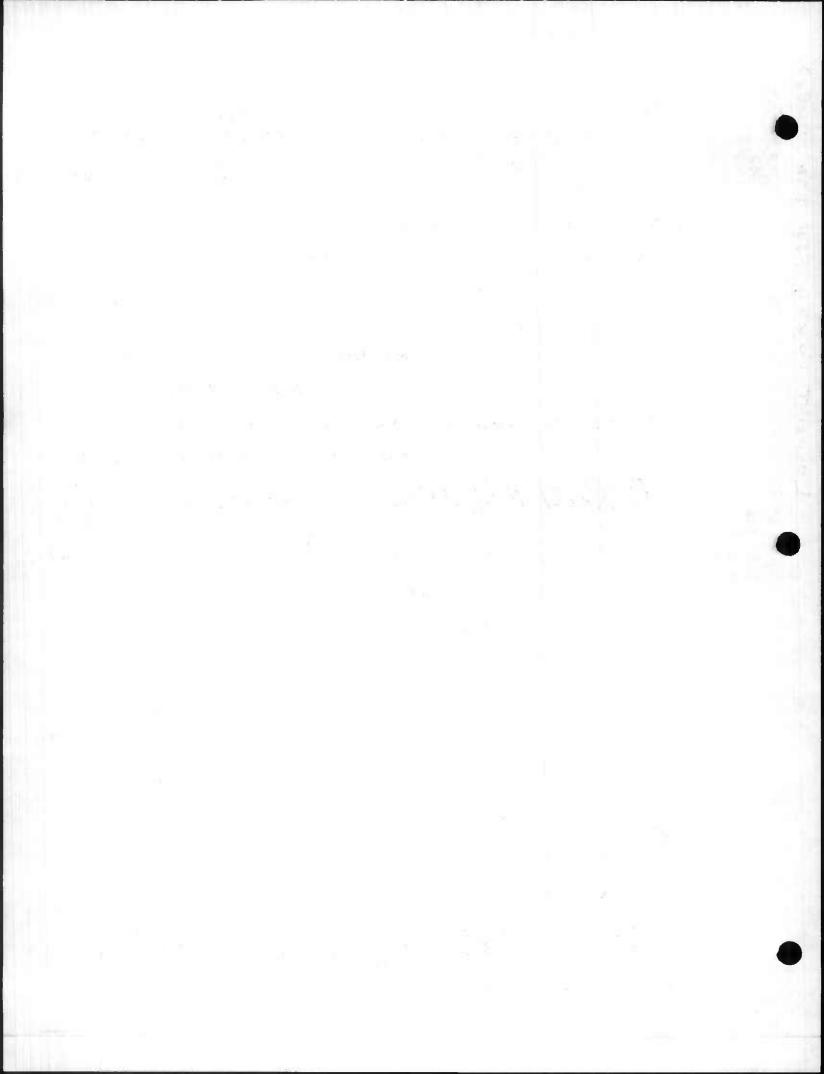
30. Name and address of person who completed cause of death (Item 23a) (Type, Print, 400 E. SHOIL

RASTKE M.O. 31. Date filed (Month, Day, Year)

APR 0 8 1999

32. Registrar's Signature

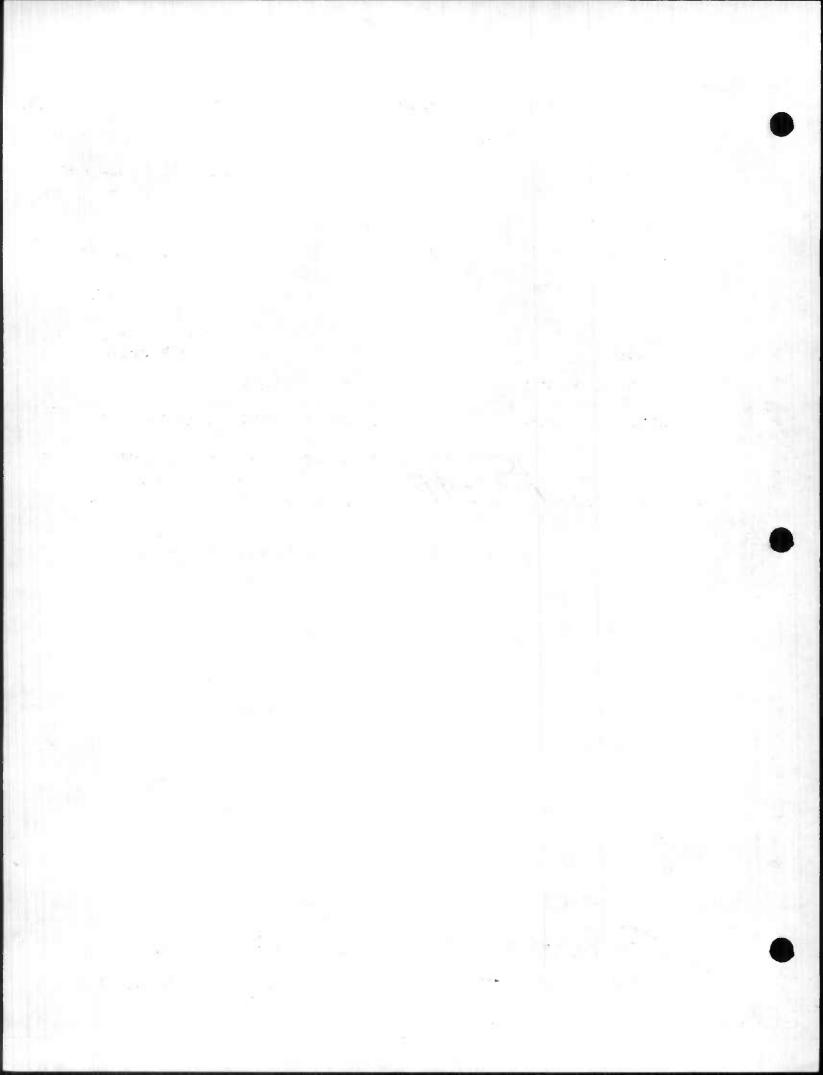
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | Certificate o | f Death | | Reg. No. | 9 | 13409 | | |
|--|---|---|---|--|---|--|------------------------------------|--------------------------|---|--|--|
| Dhysisian | 1. Decedent's Neme (First, Middle, L | ast) | | | | 2. Dete of Dea | ath Dey | Year | 3. Tima of Death | | |
| Physician /Medical | ALBERT | LOUIS | COOKSI | EY | | APRIL | 7, 1 | 1999 | 3:30 P.M. | | |
| Examiner | 4e Fecility Name (If not institution, g | | | | 4b. City, Town, or | Location of Death | , | | | | |
| Neil _ | LARKIN-CHASE | | | | BOWIE | T | | | ORGE'S | | |
| Funeral Director | 5. Social Security Number 6. 220-09-5010 Usual Residence of Decedent | Sex 7. 1 X M 2 □ F | Age (In yrs. last birt | hday) If Under 1 Yes Months Dey | | 8. Dete of Birt (Month, De) AUG . 5 | , 1917 | 9. Birthp Coun | lace (State or Foreign try) RYLAND | | |
| P 8 m | 10a. State 10b. County | | 10c. City, Town | or Location | | | | 1 | Od. Inside City Limits | | |
| with the Maryla s or 28a-f show be notified at Director | MD PRINCE | GEORGE'S | S BRA | NDYWINE | | | | | 1 ☐ Yes 2X No | | |
| 23e or 1 sattles or | | | | | 613 | 10g. Citizen of What Country? UNITED STATES | | | | | |
| ours after death v raf, or items 23 Examiner must | 3 ☐ Widowed 4 ☐ Divorced | 12. Wes Deced Armed Forc 1 Tyes 2 If Yes, Give Yeer or Dete | ** | 13. Was Decedent of If Yes, specify Cu | | pecify Yes or No- o Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Specify: WHITE | | | | | |
| 72 hg | 15. Decedent's (Specify only highest g | | 16e. | Decedent's Usuel Occ | upetion e during most of wo | rkina | 16b. Kind of Bu | | | | |
| ATATO-UDAN od within 72 hours at ypleine, wer than "natural", or et that Medical Exam Completed by F | Elementery/Secondery (0-12) 5TH | College (1-4 | lor 5+) | (Give kind of work don life. DO NOT use reti LABORER | red) | | PRINCE GOVERN | | GE'S CO. | | |
| Be C Be | | st) | | | 18. Mother's Ner | ne (First, Middle, | Maiden Sumem | ie) | | | |
| To To | | KSEY | | | EFF | IE MOREL | .AND | | | | |
| Mids od 2 sho dilh and 27 is me r traum | 19a. Informant's Neme/Reletionship MARGARET V. La | | | Meiling Address (Stre 310 CHERRY | | | | | | | |
| a Hara | 20e. Method of Disposition | | 20b. Plece of | Disposition (Neme of | | Dete | 20c. Location - | | | | |
| allumore, mit. Pages 1.1 partment of He portant: if Item y Injury or othe | 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec | | ete | RECTION CE | 1 | 4/12/99 | CLINT | ON, N | MARYLAND | | |
| 0 88888 | 21. Signature of Funerel Service Lice | 10-0 | 240 | 2. Neme end Add | | HUNTT FU | | | | | |
| DAG | DAVID A. GOF 23a. Pert1. Enter the disease, or conshock, or heart feilure. List only | F/ M010 | | P.O. B | OX 156 WA | LDORF, M | IARYLAND | 2060 | Approximete | | |
| exacuted n and isi-transit Examiner | Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): | | | | | | | | | | |
| ifficate be ng physicia as the bur Aedical | | | | | | | | | | | |
| at the death certain by the attendinetached for use | Part II. Other significant conditions | contributing to deat | 23b. Did tobacco use contribute to the cause of d | | | | | | | | |
| es that the designed by the standard be detached by Physic | | | | | | 10 | Y99 2 No | 3 Pro | bably 4 Unknow | | |
| s been s 2 should | | | | 112 | | 24e. Wes perio | en autopsy rmed? | ev co | ere autopsy findings elleble prior to mpletion of cause death? | | |
| The law page 2 | Real Control | | | | | 101 | res 25 No | 1[| Yes 2□ No | | |
| | 25. Was case referred to medical | | | | 26. Plece of De | eth (Check only o | ne) | | | | |
| 9 9 0 | examiner? 1 Yes 2 No | Hospitel: | patient 2 ER/Out | patient 3 DOA | Whor: | | | er (Specif | y) | | |
| After fune fune | 27. Menner of Deeth 1 Developed 5 Pending 2 Accident investigeti | | | jury W | | | | | | | |
| Patrice Te | 3 Suicide 6 Could not determine | 0 | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) | | | | | | | | |
| To the Hospital or Attandamining within 24 hours after deal completely filled in by the Medical Certifical | 29s. Certifier (Check only one) Certifying P Certifying P | hysician: To the be | is of examinetion and | deeth occurred et the /or investigation, in my | time, date and place opinion, deeth occu | o, end due to the erred at the time, | cause(s) and me date and pleca, | enner as s and due to | tated. the ceuse(s) | | |
| To the comple | 29b. Signeture and title of certifier | 1 | | 29c. Lice | nse number | | 29d. Date signe | d (Month, | Day, Year) | | |
| - 4 - 0 | * Ka Kes | sh or | 1019 h | 10 D | 20108 | | 4 | 7/9 | 19 | | |
| | 30. Name and address of person who RAKESH ARORA, | | | | SUITE #222 | BOWIE, | MARYLAN | ND 20 | 715 | | |
| State Registrar | 31. Dete filed (Month, Dey, Year) APR 1 3 | 32. Reg | istrer's Signeture | B. Loon | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) **Physician** 552 PM Ape,L /Medical b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number, Examiner MEDICAL If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug 3,1926 9. Birthplaca (Stata or Foreign Country) New York 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Hours Months Days 1 M 2 □ F 107-20-9782 72 **Director** Usual Rasidanca of Dacedant Pages 1 end 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If Item 27 is marked other than "natures", or items 23s or 28s-4 ehow r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Manchester 1 ☐ Yas 2X No Carroll Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 7 is marked other than "naturel", or items 23a or traumatic event, the Medical Examinar must be r 21102 3200 Farm Lane USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: White à 3 ☐ Widowed 4 ☐ Divorcad Completed 16s. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Elementary/Secondery (0-12) College (1-4or 5+) H & R Block Tax Preparer 18. Mothar's Neme (First, Middle, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Gustav Dahlquist Astrid Olsen 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Raietionship (Type, Print) Stephanie Dahlquist, wife 3200 Farm Lane, Manchester, Md 21102 other t 20b. Piece of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 Oxcramation 3 ☐ Ramovai from State Carroll Cremations 4/7 4 ☐ Donation 5 ☐ Othar (Specify) Hampstead, MD 21. Signatura of Funaral Sarvica Licansas 22. Nama and Addrass of Facility Eline Funeral Home liche 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shook, or haert feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) a INTRACRANIAL hEmorrhage Due to (or as a consequence of): M-dical **Examiner** ENDOCARDITIS WITH EMBOLIC EVENT Examiner attending physicien and for use as the buriel-transit thet the death certificate be executed Sequantially list conditions, if eny, leading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury P.O. Box 68760. Physician/Medical that initiated avants rasulting in daeth) Lest Due to (or es e consaquence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, þ 24e. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to Completed complation of causa of death? hes 2 NO 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physicien: director, 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Nnpatiant 2 ER/Outpatient 3 DOA Certification: To After this funeral 28e. Dete of injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 2 Accidant 5 Panding invastigation 2 No 24 hours efter death. 1 ☐ Yas 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 Homicida Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and manner as ststed. | Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a, Cartifian edical (Check only To the vithin 2 29d. Data signed (Month, Day, Year) 29b. Signajura and titla

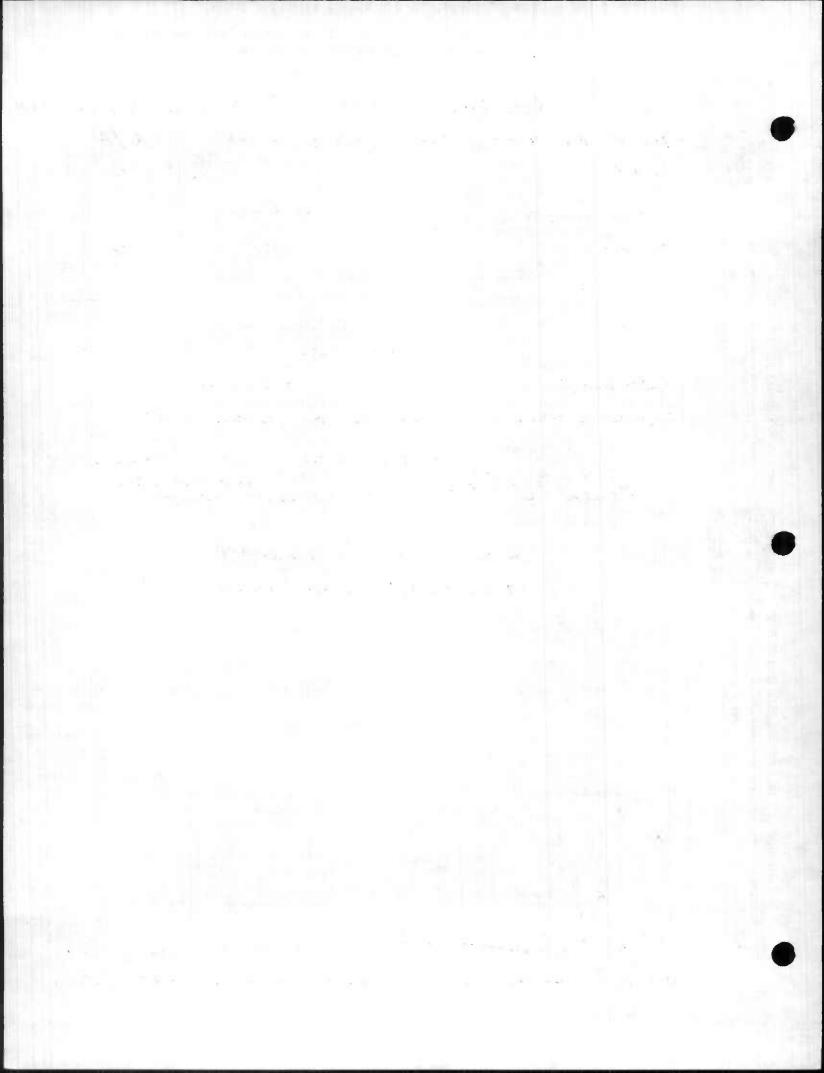
State Registrar 31. Date filed (Month, Day, Year)

Wilma

APR 1 2 1999

30. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print) Wilma Rowe, MD 22 South G 22 South 32. Registrar's Signature

GREENE St. BALTO, MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

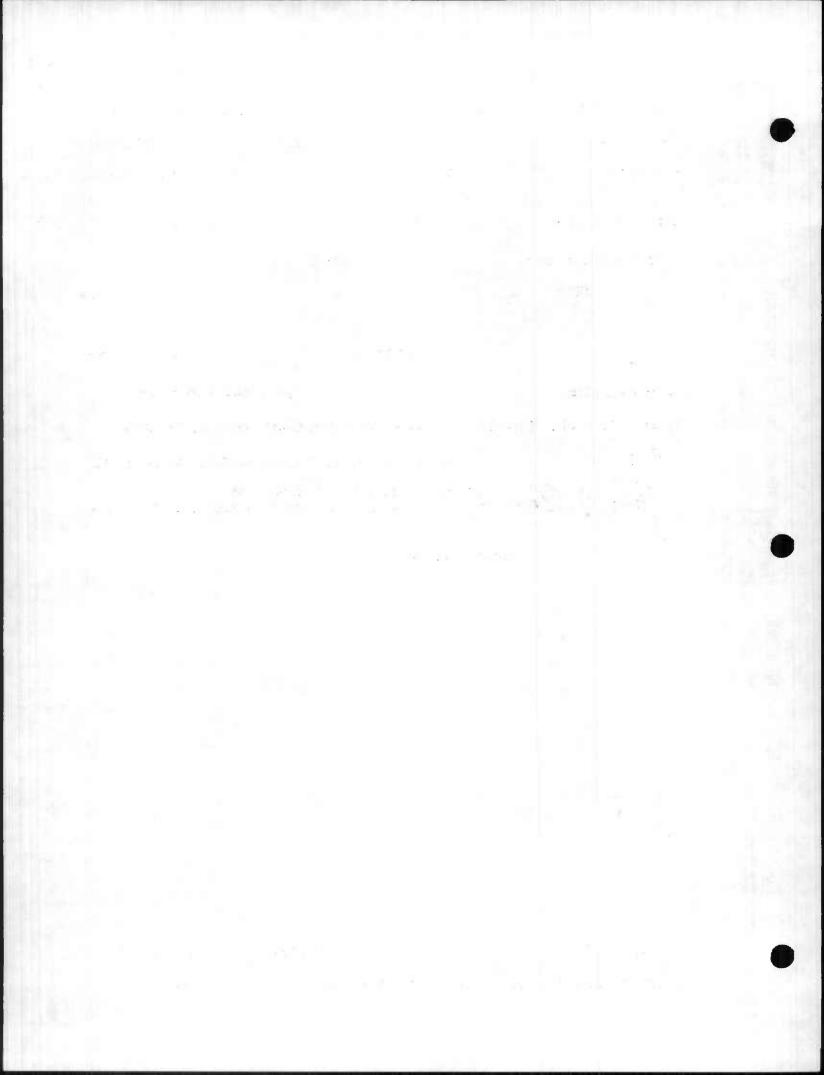
| | | | C | ertificate | of Death | Re | g. No. | 10411 | |
|--|---|---|--------------------------------------|--|---|--|-------------------------------|---|--|
| Physician | Decedent's Name (First, Middle, Last DORIS MASSEY | | | | | 2. Date of Death Month | Day Y | 3. Time of Death | |
| /Medical | 4a Facility Nama (If not institution, give | | | | 4b. City, Town, or | | 8 9 | 99 2:20 PM | |
| Examiner | 11741 Synepux | | | | Berlin | | Worce | ster | |
| Funeral Director | 5. Social Security Number 214-32-5029 Usual Residence of Decedent | DM ONE | In yrs. lest birthde Yrs. | Months | Year if Undar 24 Hrs Days Hours Min. | 8. Date of Birth (Month, Dey, 10/1/3 | Year) 9 | Birthplaca (Steta or Foraig Country) MD | |
| ylend w | 10a. State 10b. County | 1 | Oc. City, Town or | Location | | | | 10d. Insida City Limit | |
| vith the Mer or 28s-f st be notified Director | MD Worces | ter | Ber | lin | | | | 1 ☐ Yes 2 🕅 N | |
| 23a or 21 ust be no ral Dire | 10e. Street and Number 11741 Synep | ouxent RD | | 10f. Zip C | 811 | 10 | Og. Citizen of Wha | it Country? | |
| n 72 hours after death with the Meryland "natural", or frems 23s or 28s-f show porcal Experience must be notified as leted by Funeral Director | 11. Marital Status 1 Never Married 2 Married 300(Vidowed 4 Divorced | 12. Was Decedant Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | er in U,S. 1 | 3. Was Deceda if Yas, specif 1 ☐ Yas 2[| nt of Hispanic Origin? (S y Cuban, Mexican, Puerl No Specify: | pecify Yes or No- to Rican, etc.) | Black, | American Indian, White, etc. white | |
| c • 2 - | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) | | (Gi | cedent's Usual iva kind of work a. DO NOT use Cashier | Occupation done during most of worretired) | rking | 16b. Kind of Busin | | |
| ET to a | 11 17. Fathar's Name (First, Middle, Last) | | | Zasinei | 18. Mother's Na | me (First, Middle, N | | 0.010 | |
| The second | Raymond Masse | y | | | Het | tie Turne | er | | |
| and and series | 19a. informant's Name/Relationship (7 | | | | Street end Number or R | | | | |
| Heall Heall ther | Katherine M. Bo | | | - | epuxent RI | | MD 218 20c. Location - Cit | | |
| of of | 1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | r) | 20b. Place of Discometery, of Evergr | een Cei | metery | 4/12/99 | Berlin, | | |
| permit. Peg Department Important: It sny Injury o pnce. | 21. Signature of unergo Service Licen | uboli . | | | Address of Facility B | urbage F erlin, M[| | łome | |
| Physician | 23a. Part Entire to a seed or composition of the seed | plications that caused thone cause on each line. | e death. Do not | enter the mode | of dying, such as cardia | c or respiratory arre | est, | Approximata Interval Between Onset and Death | |
| /Medical Examiner | immediate Cause (Final disease or condition resulting in death) | | a CA | | | | | 2.5 YRS | |
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| trificete be executed g physician and as the buriel-transit Redical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | |
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| T et d | Part II. Other significant conditions co | ontributing to death but r | not resulting in the | e underlying car | usa givan In Part I. | | | Duta to the cause of deat □ Probably 4 □ Unknown | |
| requires | | | | | | 24e. Was a perform | | 24b. Were autopsy finding available prior to completion of causa of death? | |
| The law ete has be page 2 s | | | | | | 1 □ Ye | s 2 BNo | 1 ☐ Yes 2 ☐ No | |
| certificete rector, pag | 25. Was case referred to medical examiner? | Marriet. | | | | ath (Check only on | e) | | |
| H di | 27. Manner of Death 1 Matural 5 Pending | Hospital: 1 Inpatient 28a. Date of Injury (Month, Dey Y | 2 ER/Outpa 28b. Time (ear) | e of 28 | Other: 4 Nursing I c. Injury at Work? 1 Yes 2 No | dome 5 ☑ Reside | ow Injury occurred | | |
| deat ctor: y the | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | | - At home, farm, (Specify) | | 28f. Location (Street end Number or Rural Route N City or Town, Stete) | | | | |
| To the Hospital or within 24 hours efter To the Funeral Director Completely filled in the Medical Certi | | | camination and/or | | the time, date and place in my opinion, death occ | | | | |
| To the comple | 29b. Signature and the of certifier | 0 | All A | 29c. | License number D 43 5 | | 9d. Date signed (| Month, Dey, Year) | |
| | 30. Name and address of person who d | completed cause of deal | th (Item 23a) (Typ | pe, Print) | 0,0 | | -1/1// | 1 | |
| to | Thomas Rosent | | | | | | | | |

The Carlot

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Neme (First, Middle, L | ast) | | | | PE DI | 2. Dete of De Month | eth | | Time of Death |
|----------------|---|--|--------------------|---------------------------------------|-------------|---|--|------------------------------------|--|-----------------|
| ician dical | EMILE GORDON | DeVI | NE | | | | APRIL | 12 1 | | .5AM |
| niner | 4e Fecility Neme (If not Institution, gi | | | | | 4b. City, Town, or I | | 4c. County | of Deeth | |
| | 2400 SHADE OA | K COURT | | | | WALDOR | | СН | Dey Year 2 1999 1:1. 4c. County of Deeth CHARLES Year) 9. Birthplace (S. Country) 941 Washingt 10d. Insi | |
| al | 5. Sociel Security Number 6. | Sax 7. Age | (In yrs. last birt | hday) If Unde Months | Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Bird (Month, De | | | |
| or | 577–56–3393 Usuel Residence of Decedent | | 57 | | | | NOV 13 | 1941 | Washing | ston, D |
| | 10a. State 10b. County | | 10c. City, Town | or Location | | | | | 10d. In | side City Limit |
| to | Maryland Charles | S | Waldor | f | | | | | 1 | ☐ Yes 2☐ No |
| Director | 10e. Street end Number | | | | p Code | | | 10g. Citizen of V | Whet Country? | |
| | 2400 Shade Oak Co | ourt | | | 2060 |)1 | | TIC | 27 | |
| Funeral | 11. Maritel Status | 12. Was Decedent E Armed Forces? | ver in U,S. | 13. Wes Dece | edent of F | Hispanic Origin? (S an, Mexican, Puert | pecify Yes or No | - 14. Rec | e - American In | dien, |
| by | 1 ☐ Never Merried 2/2 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☑ Yes 2 ☐ N If Yes, Give Yeer or Detes: | 0 | 1 ☐ Yes | | | , , , , | | | |
| Completed | 15. Dacedent's E (Specify only highest g | Education | 16e. | Decedent's Usu | uel Occup | pation | kina | 16b. Kind of Bu | usiness/Industry | 1 |
| npie | Elementary/Secondery (0-12) | College (1-4or 5- | | | | during most of word) | ng | | | |
| Co | 12 | | S | ecurity | | | | | | |
| Be | 17. Father's Neme (First, Middle, Las | (1) | | | | 18. Mother's Ner | ne (First, Middle, | Maiden Sumen | 10) | |
| 2 | Lawrence DeVine | | | | | | | | | |
| | 19a. Informent's Name/Ralationship | | 19b. | Mailing Addras | is (Street | end Number or Ru | iral Route Numbi | er, City or Town, | Stete, Zip Code | 9) |
| | Lynetta P. DeVine 20e. Method of Disposition | e (Wife) | 20b Place of | Disposition (Na | me of | k Court | Waldorf, | MD 206 | | State |
| | Cremetion 3 | Removel from Stete | cemeter | y, crematory or | othar pla | | | 200. LOCATION | Ony or Town, c | 51010 |
| | 4 □ Darmion 5 □ Other (Spec | ** | Trinit | - | | Gardens | 4-19-99 | Waldor | f, MD | |
| | N 11 11 11 | MOO | 173 | TH E | hart | rein Mort | narv | | | |
| | 23a, Part Enter the disease, or cor | un | | 4433 W | hite | Pls la | White Pl | s, MD | 20695. | |
| ner | disease or condition rasulting in deeth) | a. LUNG (| Due to (or es a c | consequence of |): | | | | | 1114 |
| Examiner | Saquentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaese or Injury | b | Oue to (or es a c | onsequence of |): | | | | | |
| edicai | that initieted events | c | ue to (or es e c | onsequence of) | | | | | | |
| | resulting in deeth) Lest | | | 011304401100 017 | | | | | | |
| No. | | d | | | | | | | 1 | |
| Sici | Part II. Other eignificant conditions | contributing to death bu | t not resulting in | the underlying | cause giv | ven in Pert I. | 23b. Dld | tobacco use co | ntribute to the | cause of deati |
| Physician/M | | | | | | | 10 | Yee 2□No | Dobably | 4 Unknow |
| d by | | | | | | | 24e. Wes | an eutopsy | 24b. Wara at | utopsy findings |
| Completed | | | | | | | perfo | rmed? | complet | tion of cause |
| ршо | | | | | | | 10. | VacX X I No | | |
| BeC | 25. Was case referred to medical | | | | | 26 Place of Dec | ath (Check only o | | 10,100 | 20110 |
| ToB | exeminer? 1 Yes XX No | Hospitel: 1 ☐ Inpatier | nt 2 ER/Ou | tpetient 3 D | OA Oth | | lome XX Resi | | er (Specify) | |
| | 27. Menner of Deeth | 28a. Date of Injury (Month, Day | / 28b. T | | 28c. Inju | | 1 | how injury occur | | |
| Certification: | XXNaturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not datarmined | be nee Place of Injur | ry - At home, far | М | 1 🗆 | Yes 2 No | 28f. Location (| Street end Numb | ber or Rural Rou | ite Number, |
| Cer | | | | _ | | | | | | |
| | 29a. Cartifiar (Check only one) Certifying P | hysician: To the bast of miner: On the basis of end manner ste | examinetion and | , daath occurred Vor Investigetion | d at tha ti | ma, data and place opinion, daeth occu | , and dua to the irred at tha tima, | ceuse(s) and mo data and place, | and due to tha | ceuse(s) |
| | | | | 29 | c. Licens | se number | | 29d. Dete signe | d (Month, Dev. | Year) |
| Medical | 29b. Signeture end title of certifier | | | | | | | | | |
| edicai | 29b. Signeture end title of certifier | M. M | e Mar | | ח | 28352 | | APRIL | | 90 |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First Middle Last) 2. Dete of Deeth **Physician** Month 0820 ,1999 HildA April /Medical 4e. Facility Neme (If no institution, giva street end number)
PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SALISBURY WICOMICO 7. Age (In yrs. last birthdey) | If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 5. Social Security Number 9. Birthplace (Stete or Foreign **Funeral** 10 M 20 F Deys Yrs Director Usuel Residence of Decedent 10b. County 10a Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 12 Tes 2 No Director Wicomico SALISBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Apt /6 2

12. Was Dacedent Evar In U.S.
Armed Forces? EAST Herns 23a 1010 162 21881 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritai Stetus Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ ♣ If Yes, Give Year or Dates: Dunn 6 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ₩idowed 4 Divorced Specify: Black "natural", Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if Item 27 Is marked other than "say follory or other traumatic event, the Mass once. Elementery/Secondary (0-12) College (1-4or 5+) Doit TRI VATA NURSING SER 2 COM CALL 12 NULSIA 17. Fether Name (First, Middle, Last Be chalson Gilbert 8-MES 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Inform SALISBAKE Sylvi4 Utagther 24 Method of Disposition
1 □ Bornal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Primites 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Fecility Banks 21. Signature of Funeral Service Licensee Smoth tunkert 23a Partt. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as partial or respiratory arrest, shock or heart failure. List only one ceuse on each line. 2/82/ Approximete Intervei Between Onset end Deeth Physician /Medical immediate Ceuse (Finel disease or condition resulting in deeth) Long Conce-Examiner Due to (or es e consequence of): physician end the buriel-tran Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): USB P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai si or Attending Physician: 7 s efter death. I Director: After this certifical 25. Wes cese referred to medical examiner? Be 28. Plece of Deeth (Check only one) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 28e. Dete of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide a Funeral Di e Funeral Di eteky filled in Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) within 2 To the F 29b. Signature end title of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year)

(P)

State Registrar 31. Dete filed (Month, Dey, Year)
APR 0 6 1999

30. Need end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

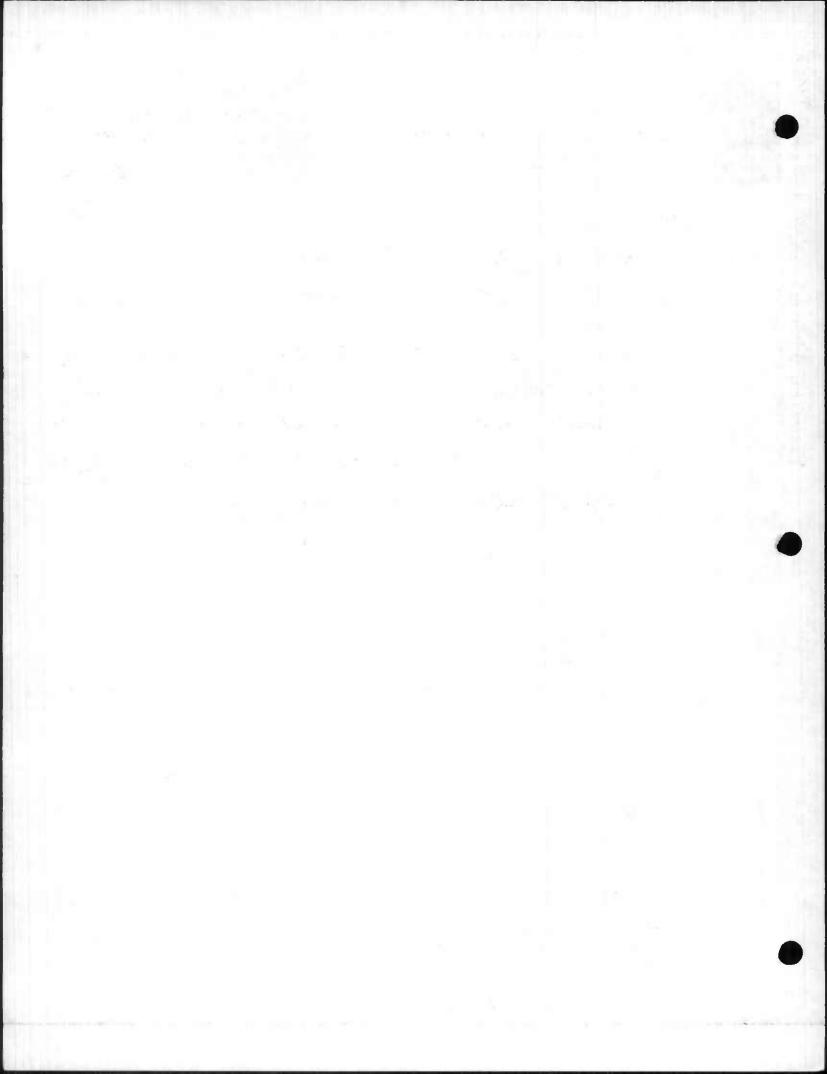
32. Registrar's Signature

u.D.

& Spark

030690

E. Carroll St., Solisbury MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3616 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dey Month **Physician** FOREMAN MARGTE 1999 8:30 AM 06 APRIL /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** BERLIN REHAB. AND NURSING HOME BERLIN WORCESTER Birthplece (State or Foreign Country) If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Deys Months Hours 1 M 2 F Director 215-74-7463 APR. 1, 1900 NEWARK. MD. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at MD. WORCESTER 1 ☐ Yes 2√ No Director BERLIN 10a, Street end Number 10f. Zip Code 10g. Citizen of What Country? 9715 HEALTHWAY DRIVE; P.O. BOX 799 21811 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
In: If Item 27 is marked other than "naturel", or ite marked other than "naturel", or ite may or other traumatic event, the Medical Engannery ☐ Yes 2 No I Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: AFRO-AMERICAN þ 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 11th DOST DOMESTIC HOUSEWIFE/RETIRED 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Be THOMAS PURNELL NANCY WATERS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SILVIA DIXON 8905 IRONSHIRE ROAD; BERLIN, MD. 21811 Baltimore. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 □XBuriel 2 □ Cremetion 3 □ Removel from Stete permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) CALVARY UMCHR. CEM 4-10-99 BERLIN, MD. 21. Signature of Funerel Service Licens 22. Neme and Address of Fecility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 23a. Part I. Errer the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock of heart feilure. List only one cause on each june. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner CV 61 buriel-transit and Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) the death certificete be execu physician P.O. Box 68760 Physician/Medicai the Due to (or es e consequenca of) use as Pol ned by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, þ sign. 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed been hes pege 2 1 Yes 2 No 1 Yes X No certificate Division of Vital 25. Wes case referred to medical examiner? Attending Physician: director. Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4X Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 2 this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending Investigation Injury Hospital or Attending
 124 hours after death.
 Funerel Director: After 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. Medical 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end tille of artifler 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

FEDERICO G. ARTHES 31. Dete filed (Month, Day, Year) APR 0 8 1999 46 TEAL CIRCLE 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death fillers 23a) (Type, Print)

OCEAN PINES MD 21811

D02026

manage from the gard of states 50 1/64 an and the person are made 219 (5.3) most as all exposed in the Board

| ERNEST RUDOLPH FENTRESS ## Colly Never (Irror intriductor, per moral and marked) ## Action | 1. Decedent's Neme (Fir | rst, Middle, Las | t) | | Certific | 2.0 01 | | 2. Dete of | | 3. Time of Death |
|--|--|--|--------------------------|--------------|--|---|--|---|--|--|
| Atlantic Ceneral Hospital Berlin Alantic Ceneral Hospital Berlin Social Security Number Social Se | FRUESI | RUDOL | PH FENT | TRES | S | | | | | 1650 PM |
| Attantic General Hospital S. Scoll Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortly Pumber S. Scortl | cal 4. Facilly Name (6-14 | | | | | | 4b. City, Town, | | | |
| 216 44 9505 1 | | neral h | lospital | | | | | | Worce | ester |
| Top College Top County Top College T | 216 44 9505 | 5 11 | DM OFF | | Mont | | | in. (Month, | Birth Dey, <i>Year)</i> 20, 1913 | 9. Birthplece (State or Fore Country) Washington, I |
| 13 15 15 15 15 15 15 15 | 10e. Stele 10b | . County | er | | | | | | | |
| 12. Was Departed of Hisperic Crigory (Specify Yee or No-American Indian, Married 2M Ma | | Main St | treet | | | | | | | |
| 1 1 1 1 1 1 1 1 1 1 | | Maiii 3 | 12. Wes Decedent I | Ever in U.S. | | | Hispenic Origin? | (Specify Yes or | | e - American Indien, |
| Clayer (in yieth physics) Codes (in I-do 54) Elegal Department - Lawyer U.S. Navy | 1 Never Merried | | Yes 2 N | Vo | | | | erto Rican, etc.) | | |
| Legal Department - Lawyer U.S. Navy | 15. I (Specify or | Decedent's Ed | ucation de completed) | | 16e. Decedent's U | suel Occup work done | oation during most of a | vorking | 16b. Kind of Ba | usiness/Industry |
| 18. Mether's Name (First, Middle, Marchan Summers) 18. Mether's Name (First, Middle, Marchan Summers) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19. Informatics Name (First, Marchan) 19 | Elementery/Secondery | y (0-12) | | 5+) | | | | | U.S. I | Navy |
| 19b. Naling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 316 South Main Street Berlin, Maryland 21811 20c. Method of Disposition 1 Bural 2 Commetter of Disposition (America) Date 2 20c. Location - City or Town, State Cameranny, cramacicy or other piges) Date 2 20c. Location - City or Town, State Cameranny, cramacicy or other piges) Date 2 20c. Location - City or Town, State Cameranny, cramacicy or other piges) Date 2 20c. Location - City or Town, State Cameranny, cramacicy or other piges) Date 2 20c. Location - City or Town, State Date 2 20c. Location - Ci | 17. Fether's Neme (First | , Middle, Last) | 31 | | Legal De | par ti | T | | dle, Maiden Sumen | ne) |
| Part See Part Cale Part P | John Fentr | ess | | | | | Martha | Baumar | nn | |
| 20c. Method of Disposition 1 20c. Exercise 20c. Exerci | | | | | | | | | | |
| Cape | | | ess | not Di- | | | in Stree | - | | |
| 22. Signature of unifold Spriffs Licensee 23. Part Lend the addition of depolar spriffs and the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part Lend the addition of depolar spriffs and the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 24. Part Lend the addition of death of the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Part Lend the addition of death of the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 26. Due to (or as a consequence of): 27. Due to (or as a consequence of): 28. Place of Deeth (Check only one) 29. Place of Deeth (Check only one) 29. Place of Injury at | | | Removel from State | Car | metery, cremetory | or other pla | ca) | Date U/10/ | 20c. Location - | |
| Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Parti. Enter the definition or definition or definition or definition and the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the definition of the deeth of the deeth of deeth of deeth or deeth of deeth of deeth of the deeth of de | 4 Donetlon 5 D | Other (Specify |) | Cap | | | | 7 4/10/ | 55 1 I dill | KIOIG, DE |
| 24e. Wes en eutopsy performed? 24e. Wes en eutopsy performed? 24e. Wes en eutopsy performed? 25. Wes case referred to medical exeminer? 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 27. Menger of Deeth 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 27. Menger of Deeth 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Deeth (Check only one) 28. Plece of Injury one) 28. Pl | disease or condition | 1. | e. P^ | 3/44 | | | | | | |
| 1 Yes 2 No 3 Probably 4 Unkn | Sequentielly list condition if eny, leading to immed cause. Enter Underlying Ceuse (Disease or Injury that initial end events | ons, liate | b. Chron | Due to (or e | obstvuc es e consequence | hve of): | polmon | rang d | islor | 5 yours |
| 24e. Wes en eutopsy performed? 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? 1 | Sequentielly list condition if eny, leading to immed cause. Enter Underlying Ceuse (Disease or Injury that initial end events | ons, liate oy | b. Chron | Due to (or e | obstvuc es e consequence | hve of): | polmon | rang d | slor | 5 yours |
| 25. Wes case referred to medical exeminer? 1 | Sequentielly list condition if eny, leading to immediate. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest | ι | b. Chron | Due to (or e | obstructus es e consequenca | of): | pulmar | | | |
| 25. Wes case referred to medical exeminer? Yes 2 No | Sequentielly list condition if eny, leeding to immed cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest | ι | b. Chron | Due to (or e | obstructus es e consequenca | of): | pulmon | 23b. D | ild tobacco use co | entribute to the cause of dea |
| exeminer? Neturel Second | Sequentielly list condition if eny, leading to immed cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest | ι | b. Chron | Due to (or e | obstructus es e consequenca | of): | pulmov | 23b. D 1 | oid tobacco use co ☐ Yes 2☐ No //es en eutopsy | ontribute to the cause of dea 3 Probably 4 Unkn 24b. Were eutopsy finding eveileble prior to completion of cause |
| 1 Yes 2 No | Sequentielly list condition if eny, leading to immediate. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest | ι | b. Chron | Due to (or e | obstructus es e consequenca | of): | pulmon | 23b. D 1 24e. W | id tobacco use co | 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? |
| 2 Accident 3 Suicide 4 Homicide See Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of partition 29c. License number 29d. Datagraphed (Month, Day, Year) | Sequentielly list condition if eny, leeding to immedicause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Pert II. Other significant 25. Wes case referred.to | conditions co | b. Chron c | Due to (or e | obstructus es e consequenca | hvc of): | 28. Piece of I | 23b. D 1 24e. W | id tobacco use co | 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? |
| 4 Homicide determined building, etc. (Specify) 29e. Certifier (Check only one) 29 Medicat Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted. 29b. Signeture and title of partition 29c. License number 20d. Date pigned (Month, Only, Year) | Sequentielly list condition if eny, leading to immedicause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Pert II. Other significant 25. Wes case referred to exeminer? 1 Yes 2 No | conditions co | b. Chron c | Due to (or e | es e consequenca es e consequenca ting in the underlying | hve of): of): og cause gi | 28. Plece of I her: 4□ Nursin | 23b. D 1 24e. W pt 1 Deeth (Check on g Home 5 🗆 R | lesidence 6 Off | ontribute to the cause of dea 3 Probably 4 Unkn 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? 1 Yes 2 No |
| (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and the of partition 29c. License number | Sequentielly list condition if eny, leading to immedicause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Pert II. Other significant 25. Wes case referred to exeminer? 1 Yes 2 No 27. Menger of Deeth 1 Neture 5 [| o medical | b. Chron c. d | Due to (or e | es e consequence es e consequenca ting in the underlying R/Outpetient 3□ 28b. Time of Injury | DOA OII | 28. Plece of I her: 4□ Nursin ry et rk? | 23b. D 1 24e. W po 1 1 Deeth (Check on g Home 5 □ R 28d. Descril | id tobacco use co Yes 2 No Yes en eulopsy arformed? Yes 2 No (y one) esidence 6 Oth be how injury occur | antribute to the cause of dea 3 Probably 4 Unkn 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? 1 Yes 2 No |
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| 30. Name and address of person who completed cause of death (Item 23a) (Type Print) | Sequentially list condition if eny, leading to immedicause. Enter Underlying Ceuse (Disease or Injury that Initialed events resulting In deeth) Lest Pert II. Other significant 25. Wes case referred to exeminer? 1 Yes 2 No 27. Menger of Deeth 1 Neturel 5 2 | p endical Pending Investigation Could not be determined | b. Chrow c. d | Due to (or e | es e consequence es e consequenca es e consequenca ting in the underlying ER/Outpetient 28b. Time of Injury M ne, farm, street, fer | DOA Other land of the land of | 28. Plece of I her: 4 \(\to \text{Nursin} \) ry et rk?] Yes 2 \(\text{No} \) me, date end ple | 23b. D 1 24e. W po 1 Deeth (Check on g Home 5 R 28d. Descrii 28f. Locatio City or | id tobacco use co Yes 2 No Yes an eutopsy arformed? Yes 2 No Iy one) esidence 6 Oth be how injury occur in (Street end Numble Town, Stete) | ontribute to the cause of dee 3 Probably 4 Unkn 24b. Were eutopsy finding eveileble prior to completion of cause of deeth? 1 Yes 2 No ner (Specify) rred ber or Rural Route Number, anner as steted. |
| 30. Name and address of person who completed cause of deeth (Item 23a) (Type Print) | Sequentielly list condition if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Lest Pert II. Other significant 25. Wes case referred to exeminer? 1 | p medical Pending investigation Could not be determined Certifying Phy Medical Exam | d | Due to (or e | es e consequenca es e consequenca es e consequenca ting in the underlying ting in the underlying es. Firme of linjury Mone, farm, street, fective dedge, deeth occur on end/or investiga | DOA Other land of the trick of | 28. Plece of I her: 4 \(\to \) Nursin ry et rk?) Yes 2 \(\to \) No me, date end ple opinion, deeth of se number | 23b. D 1 24e. W po 1 Deeth (Check on g Home 5 R 28d. Descril 28f. Location City or sece, and due to to courred et the time | lid tobacco use co Yes 2 No Yes an eutopsy artormed? Yes 2 No No No No No No No No | anner as steted, and due to the cause of dea |
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the same of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day APRIL 1999 9:30PM 11 FRANCES CATHERINE FLEMING 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER PLATA CHARLES LA 5. Social Security Number If Under 1 Yeer if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 TF Months Days Hours Min. Yrs 210-26-8443 Usual Residence of Decedent June 29 1934 Illinois 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1□Yes 2□No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 Old Washington Road 20601 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hospital Telecommunications Elementary/Secondary (0-12) Coilege (1-4or 5+) Assistant Director 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Schaffer Anna Toland Schaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Andrew Bauer (son) 3004 Hickory Valley Drive Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 4-13-99 Alexandria, VA 21. Signati 22. Name and Address of Facility M00173 J.H. Eberwein Mortuary 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 4433 White Pls 1a White Pls 7 MD 20695 Approximate Interval Between Onset end Death Immediete Cause (Finel disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

notifies

ed other than "natural", or items 23a or event, the Medical Examiner must be

Directo

Funeral

by

Completed

86

To

The Maryla

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Pages 1 and 2 should be

Mental marked

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item 27

important: If it any injury or

Baltimore, Maryland

Examiner physician and s the burial-transit attending pt signed by the a

Physician/Medical þ Completed Be 10 Certification:

that the death certificate be executed law requires certificate has b The Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, A 24 hou. he Funeral Dir.

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Localion (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert T. Pace, MD. 12070 Old Line Center Suite 202 Waldorf, Maryland 20602

Injury

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

31. Date filed (Month, Day, Year) APR 13 1999

5 Pending investigation

6 Could not be determined

Natural

2 Accident 3 Suicide

4 Homicide

(Check only one)

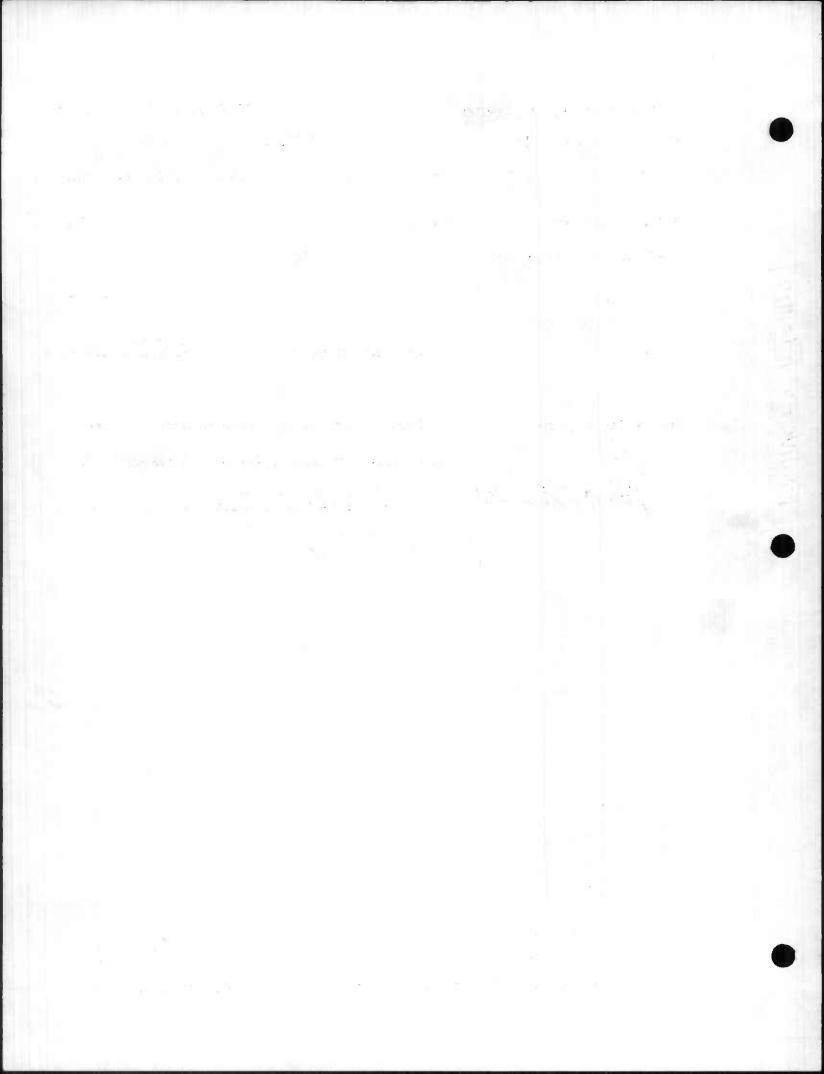
29b. Signeture end title of capit

29a. Certifier

32. Registrar's Signature

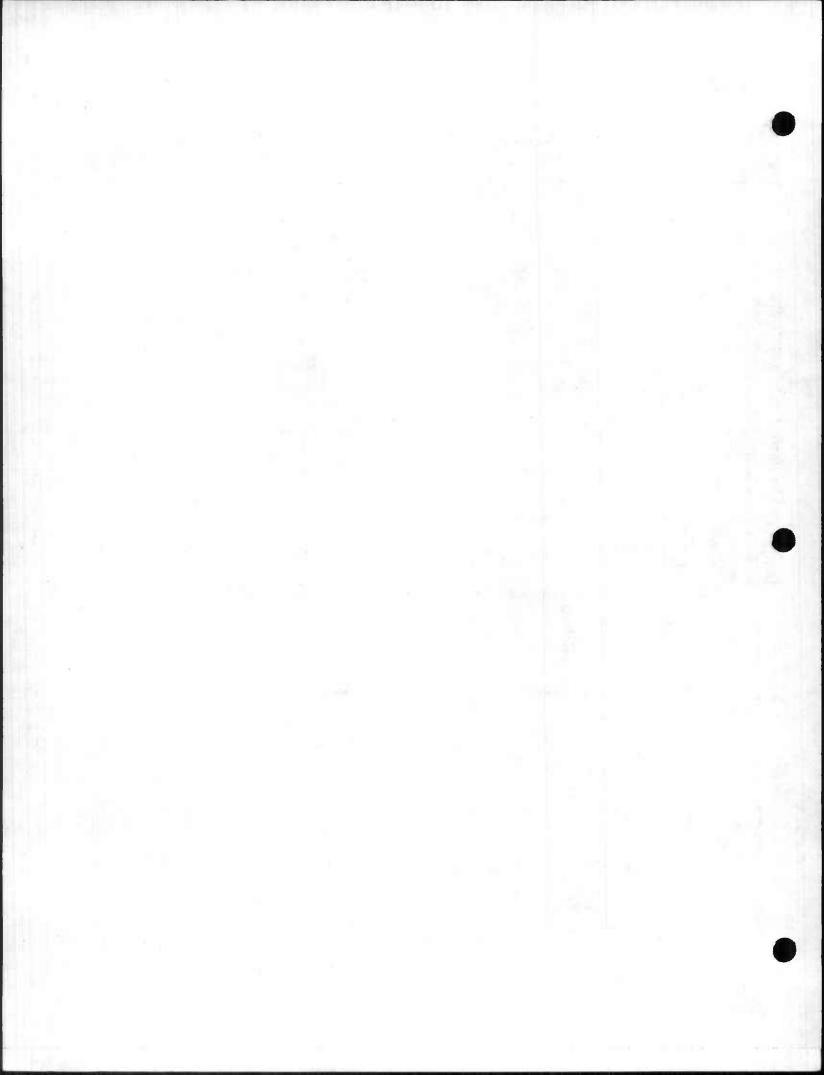
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To the Hosp within 24 hos To the Fune completely fi



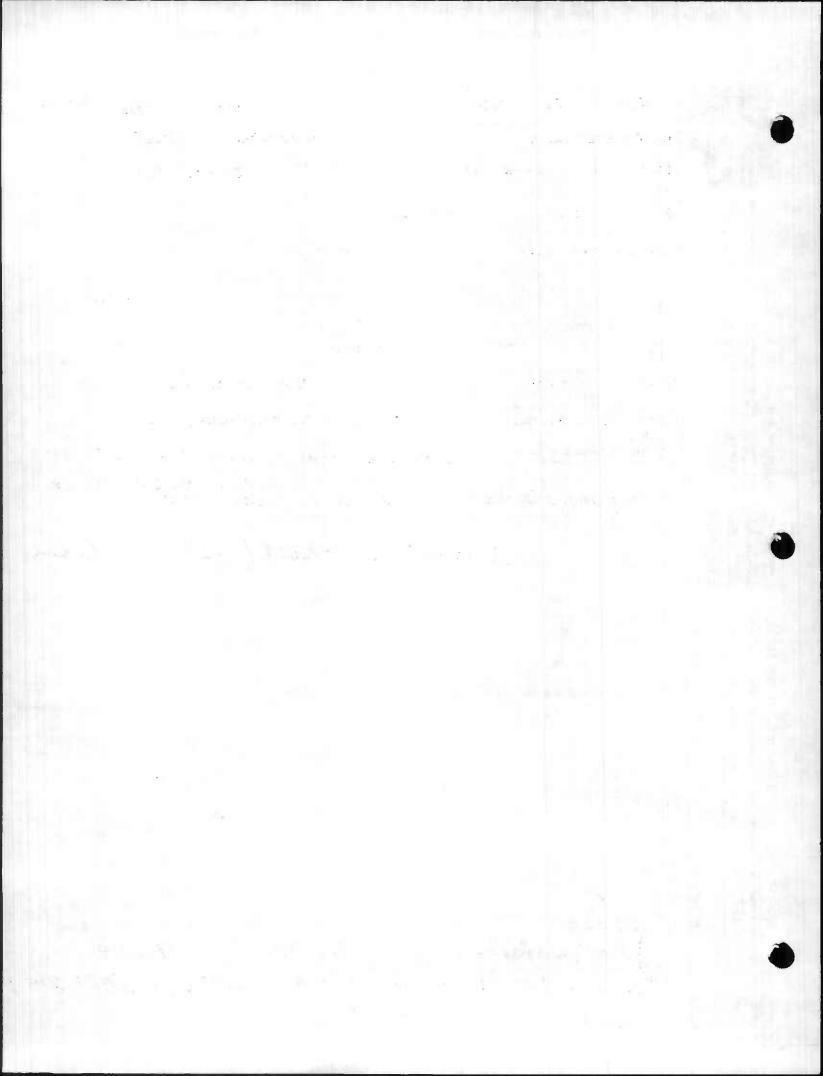
State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Nama (First, Middle, L | ast) | | Certificate of | Death | 2. Date of Dear | eg. No. | | 3. Time of Death |
|--|--|--|-------------------------------|---|------------------------------|-------------------------------------|------------------|---|---|
| Physician | and the state of t | elle Gouge | | | | Month April | 7, 19 | Year 99 | 2109 |
| /Medical Examiner | 4a Facility Name (If not institution, g | | | | 4b. City, Town, or I | | 4c. County | | 2203 |
| LAdmine | Carroll County | General Hos | pital | | Westmi | nster | Ca | rroll | |
| Funeral Director | 242-36-9682 | 1 N 28 E | (In yrs. last birth | day) If Under 1 Year Months Days | | (Month, Day | ,1922 | Country) | e (State or Foraign |
| pu a | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. | Inside City Limits |
| 28a-f sho cottned a | Maryland Carro | | | | Millers | | 0-00 | | 1□ Yes 2⊠ No |
| fier death with the Me r items 23s or 28s-fe for ment be notified Funeral Director | 4022 Grave Run | | | 10f. Zip Code | 21102 | | 0g. Citizen of V | SA | |
| by | 11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced | 12. Wes Decedent Ev Armed Forcas? 1 Yas 2 No If Yes, Give Yaar or Detes: | | 13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No | | pecify Yes or No- o Rican, etc.) | | e - American k, Whita, etc. : Whi | |
| be filed within 72 ho nal Hygiena. I other than "naturi avent, ma trace all Be Completed | 15. Decedent's I (Specify only highest g | ducation rada completed) | 16a. C | Decedent's Usual Occu Give kind of work done ife. DO NOT use retire | pation during most of wor | king | 16b. Kind ol Bu | sinass/Indus | try |
| Hp. hen | Elementary/Secondary (0-12) | College (1-4or 5+) |) | ife. DO NOT use retire HOUSEW | | | Oturn | Home | |
| Hed Had | 17. Father's Name (First, Middle, Las | t) | | nousew | | na (First, Middla, I | | | |
| marked other marked other marked other marked other marked other marked avent. | Walter Hughes | | | | | resnell | | ٠, | |
| d d d d d d d d d d d d d d d d d d d | 19a. Informant's Name/Relationship Blaine W. Gouge | | | Meiling Address (Stree 122 Grave R | | | | | de) |
| A F F F | 20a. Method of Disposition | 75 0 | 20b. Place of E | Disposition (Name of crematory or other pla | ace) | Date | 20c. Location - | City or Town | , Stata |
| | 12 Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec | | | rs Cemeter | | 4/10 | Mille | ers, M | |
| permit. Page Department of Important: If any injury or poce. | 21. Signature of Funeral Service Lice | insee 1 7 4 | 200 | 22. Name and Addr | ess of Facility The Main St | line Fun | | | 1 |
| | 23a. Part1. Enter the diseese, or con | nplications that caused the | he death. Do no | | | - | | . Ac | proximata |
| Physician | shock, or heart failure. List onl | | | | | | | | erval Between nsat and Death |
| /Medical | Immediate Cause (Final diseasa or condition | . VENT | RICU | LARF | IBRILL | 17101 | V | . Qr | retout |
| xaminer | resulting in death) | D | ue to for se s co | nsequence of): | | | | | 2 born |
| # e | | GASTR | OINT | ESTINAL | - BLE | EDIN | 7 | 1 | Tren |
| physician and street transit edical Examiner | Sequentially list conditions, if any, leading to immediate | Di | ue to (or as a co | nsequence of): | | | | | |
| buris cal | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events | C | | | | | | 1 | |
| physicians the bur | resulting in death) Last | Di | ue to (or as a co | nsequence of): | | | | | |
| ettending i for use es | | d | | | | | | | |
| od for | Part II. Other significant conditions | contributing to death but | not rasulting in t | he underlying cause g | iven in Part I. | 23b. Dld to | bacco uss cor | stributs to th | e causs ol death |
| d by the ettending etteched for use Physician/M | Dialago | To Rel | Wes | | | 1 🗆 Y | 88 2 No | 3 Probab | ly 4 Unknow |
| A A | 110000 | | hours | 0 | | | | | |
| cate has been signed by the page 2 should be detached Completed by Physic | confer | itee He | and H | a lu | P | 24a. Was a perfor | | availa | sutopsy findings ble prior to letion of causa |
| page 2 | | | 1 | | | | _/ | of dea | |
| | 06 111 | | | | | 1 🗆 Yı | | 1 U Y | as 2 No |
| director, | 25. Was case referred to medical axaminer? 1 Yes 2 No | Hospital: | 2 DERVOUTE | atient 3 DOA O | ther | th (Check only or | | (Ci4-) | |
| E 0 = | 27. Mannar of Death | 28a. Date of tnjury | 28b. Tir | ne of 28c. Inju | | 28d. Describe h | | | |
| leath. for: After the funer Cation | 1 Naturat 5 Pending 2 Accident investigation | (Month, Day) | rear) Inj | | ork?]Yes 2□No | | | | |
| | 3 Suicide 6 Could not determine | | y - At home, lam (Specify) | n, street, factory, office | | 28f. Location (Si City or Town | treet and Numb | er or Rural R | oute Number, |
| O TO TO TO TO TO TO TO TO TO TO TO TO TO | | | | | | | | | |
| in 24 hours after the Funeral Dir plets by filled in edical Cert | | hysician: To the best of a miner: On the basis of a | xamination and/ | | | | | | |
| within 24 hours To the Funerel Completely filled Medical Ce | 29b. Signature and title of certifier | and manner state | anna 1 | 10 29c. Licen | se number | 2 | 9d. Date signed | (Month, Day | y, Year) |
| | | | | שו | 0 000 | 4 | TI | 17 | 2 |
| | 30. Nama and address of person who CHITNI-CHED Y N | pompleted cause of dea | th (Item 23a) (T | ype, Print) A Post | - Rel was | (mi.met | MD | 211 | 57 |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar | | 6 1 | | | | | |
| Registrar | APR 1 2 | 1999 | yeva | D. And | uly | | | | |

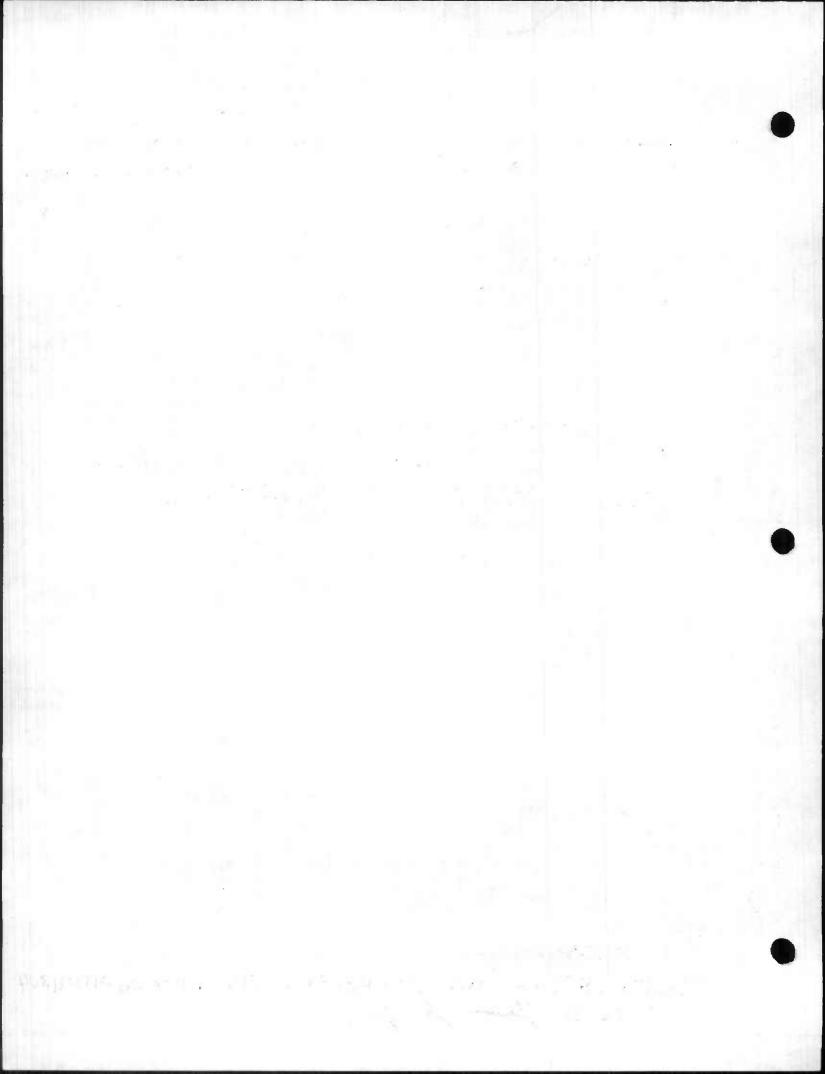


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Dhyaisian | 1. Decedent's Nan | | | 1 | | | | | | 2. Dete of D Month | eath Dey | Year | 3. Time of Death |
|--|--|--|---|--|---------------------|---|--|---|----------------------------|--|--|--|--|
| Physician /Medical | Shir | | | leau | | | ľ | 41. Oh. T. | | April | 6 19 | 99 | 6:30am |
| Examiner | | (If not institution, git dinal Dri | | umber) | | | | Westm | inst | cation of Dea | 4c. County | _ | |
| Funeral Director | 5. Social Security I 214-24-2 | 414 | Sex 1 □ M 2 汉 F | 7. Age (In yr 70 | | day) If Und Month | der 1 Year Days | | 24 Hrs. Min. | 8. Dete of B (Month, D June | irth Pay, Year) 17 1928 | Cou | place (Stete or Fore intry) |
| -f ehow | Usuel Residence of 10a. State Md | 10b. County Carroll | | | City, Town | or Location | | | | | | | 10d. Inside City Lim |
| 23a or 28a-f et ant be notified al Director | 10e. Street and Nu 6997 Bea | ehmont Dr | rive | | | 10f. 2 | Zip Code 2178 | 4 | | | 10g. Citizen of V USA | What Cou | intry? |
| at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director | 11. Maritai Status 1 Never Mar | rled 2 Married | Armed F | 2 No | U,S. | | cedent of I pecify Cub 2 DNo | | | ecify Yes or N Rican, etc.) | Ble | ca - Americk, White | |
| fedical ledical | (Spe Elementery/Sec 12 | 15. Decedent's E ecify only highest gr ondery (0-12) | ede completed | f) (1-4or 5+) | 16a. (| Decedent's Us 'Give kind of N life. DO NOT home | sual Occup work done use retire | during mos d) | st of worki | ing | 16b. Kind of B | | ndustry |
| Se ever | 17. Father's Name | (First, Middle, Last choenfeld | | | | | | | | (First, Middle McLau | e, Maiden Suman ughlin | ne) | |
| 7 ie m traum traum | | lame/Retationship | |) | | | | | | | ber, City or Town, MD 21 | | ip Code) |
| Y Or of | | sposition Cremation 3 E 5 Other (Speci | | | | Disposition (A crematory of Park (| | | 4- | Dete -9-99 | 20c. Location Baltimo: | | |
| Important: any injury pncs. | ^ | uneral Servica Lice | | 1014 | | | and Addre | ess of Fecili | Ha | | uneral H | ome 8 | & Chapel |
| | 23a. Part1. Enter | the disease, or con art feilure. List only | nplications that | caused the de | alh. Do no | P.O. If | | - | | | | | Approximate Interval Between |
| aminer | 23a. Part1. Enter shock, or her Immediate Cause disease or conditi resulting in death) | the disease, or con art feilure. List only (Final on | nplications that | caused the de each line. | lost (or as a co | onsequenca c | of): | ing, such as | s cardiac | | arrest, | | Approximate Interval Between Onset and Deett |
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| be completed by Physician/Medical Examiner | 23a. Part1. Enter shock, or her shock, or her disease or conditions and the second shock of the | the disease, or con art feilure. List only (Final on onditions, modulate ertying r injury is Last | b d | Due to Due to | (or as a co | onsequence of the underlying | orth: | ing, such as | Cly | 23b. Did 10 24a. We per | d tobacco use colly yes 2 No | 3 Pro | to the cause of de obably 4 Unkil Vere autopsy findin visilable prior to completion of cause of deeth? |
| his certificate has been signed by the attending physician and a firector, page 2 should be detached for use as the buriel-transit. | 23a. Part1. Enter shock, or her shock, or her disease or conditions and the second shock of any, leading to it cause. Enter Und Cause (Disease of that initiated eveniresulting in death) Part ff. Other eigni | the disease, or con ant feilure. List only (Final on on onditions, mmediate ertying rinjury is Last | b c d Hospital: 1 28a. Date Model and the property of the property | Due to Due to | (or as a co | onsequence of the underlying | orde of dying order of dying order of dying order orde | ing, such as | I. | 23b. Did 10 24a. We per 10 11 11 11 11 11 11 11 11 11 11 11 11 | d tobacco use collyee 20 No | 3 Pro 24b. V a c c c c c c c c c c c c c c c c c c | to the cause of de obably 4 Unkil Vere autopsy findin visilable prior to completion of cause of deeth? |
| orearn. the funeral director, page 2 should be detached for use as the burish-transit the funeral director, page 2 should be detached for use as the burish-transit augment cation: To Be Completed by Physician/Medical Examiner | 23a. Part1. Enter shock, or her shock, or her disease or conditions and the shock of the shock o | the disease, or con art feilure. List only (Final on onditions, mmediate ertying r injury is: Last | b d Hospital: 1 28a. Date (Moon) 28e. Place | Due to Due to Due to Due to Due to Due to Due to Due to | (or as a co | onsequence of the underlying the underlying me of jury M | DOA Ot 28c. Inju Wc | 26. Piecher: 4 N | I. | 23b. Did 1 [24a. We per 1 [check only me 5 [Re- 28d. Describe | d tobacco use collection of th | 3 Production 24b. Value of the Control of the Contr | to the cause of decobebly 4 Unkr Vere autopsy findin valiable prior to completion of cause of deeth? Yes 2 No |
| Shours after death. Funeral Director: After this certificate has been signed by the attending physician and tay filled in by the funeral director, page 2 should be detached for use as the burish-transit. To Be Completed by Physician/Medical Examiner. | 23a. Part1. Enter shock, or her shock, or her disease or conditions and the second shock of the | the disease, or con ant feilure. List only (Final on onditions, mmediate ertying rinjury is: Last difficant conditions of the conditions o | hysician: To the minar: On the limit on the | Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to | (or as a co | onsequence of onsequence of onsequence of the underlying me of jury Mem, street, fact | DOA Ot 28c. Inju Wo 1 Cory, office ed at the t | ven in Part 26. Plec her: 4 \(\text{N} \) inven in ven in part inven in part | I. Se of Death dursing Ho | 23b. Did 24a. We per 1 Check only me 5 Re. 28d. Describe City or T and due to the | d tobacco use colly to the total of the tobacco use colly to the tobacco use colly the t | 3 Production 24b. Value of the Control of the Contr | onset and Deeth to the cause of decobably 4 Unker Vere autopsy findin viailable prior to completion of cause of deeth? Yes 2 No |
| his certificate has been signed by the attending physicial director, page 2 should be detached for usa as the but To Be Completed by Physician/Medical | 23a. Part1. Enter shock, or heir shock, or heir shock, or heir shock, or heir shock, or heir shock, or heir shock or conditions of the shock of the | the disease, or con art feilure. List only (Final on on on on on on on on on on on on on | hysician: To the minar: On the limit on the | Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to | (or as a co | onsequence of the underlying the underlying Mm, street, fact | DOA Ot 288. Inju. Word 1 Etory, office ed at the trion, in my | ven in Part 26. Plec her: 4 \(\text{N} \) inven in ven in part inven in part | I. Se of Death dursing Ho | 23b. Did 24a. We per 1 Check only me 5 Re. 28d. Describe City or T and due to the | d tobacco use colly to the total of the tobacco use colly to the tobacco use colly the t | 3 Production Productio | ompletion of cause of deeth? Yes 2 No No No No No No No No No No |

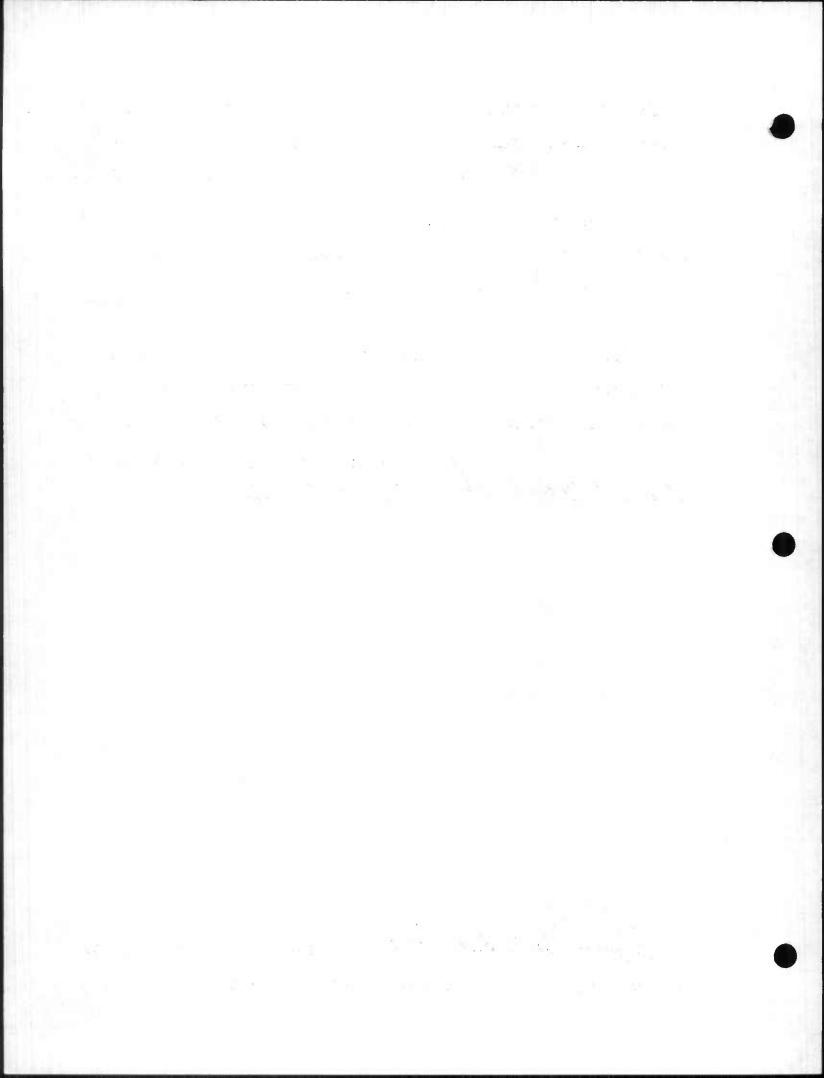


| | | | | | Certifica | | Death | | Reg. No. 9 9 | | 3419 |
|---|----------------|--|--|-----------------------|------------------------------------|-------------------------------|---|--------------------------------------|--|--------------------------|---------------------------------------|
| | | 1. Decedent'a Nama (First, Middla, L | ast) | | | | | 2. Data of Di Month | | Yaar | 3. Tima of Death |
| Physician | _ | Emma | Lois | | | | Hodge | - 17 | Day 10, 1999 | Taar | 4:05 AM |
| /Medica Examine | | 4a Facility Nama (If not institution, g | iva street and number) |) | | | 4b. City, Town, or | | | of Death | 4.02 Wil |
| LAMITIME | CI | Salisbury Center | · Conosis | FldorCar | ^^ | | Salisbur | z MD | Wigom | | |
| | | | | ga (In yrs. last bir | | der 1 Year | If Under 24 Hrs. | | Wicom | | aca (State or Foreign |
| Funeral | | 140-12-1834 | IDM ONE | Supplied to Contr | Yrs. Month | ns Days | Hours Min. | 8. Data of Bi | ay, Year) | | aca (Stata or Foraign |
| Director | | Usual Rasidence of Decedent | | 4 | | | | Aug.1 | 1924 | enn | sylvania |
| Du B | | 10a. Stata 10b. County | | 10c. City, Tow | n or Location | | | | | 10 | Od. Insida City Limits |
| ah da | 5 | | | | | | | | | | 1 ☐ Yas 2 No |
| 2 3 | 200 | Maryland Wico | mico | A | sbury | | | | | | • |
| £ 20 5 | Director | 10e. Street and Number | | | Md. 10f. | Zip Code | | 100 | 10g. Citizen of W | /hat Coun | ry? |
| 23a | | 6313 Feather H | eights DF | R.Salis | bury | 2 | 1801 | | U.S.A | | |
| within 72 hours after death with the Manyland ana. than "natural", or Nama 23a or 28a-f ahow the Marcal European must be notified at | Funeral | 11. Maritaf Status | 12. Was Decedent Armed Forcas? | | 13. Was De | cedent of F | lispanic Origin? (S an, Mexican, Puart | pecify Yas or N | 0- 14. Race | - Amarica k, Whita, a | |
| o a garage | | 1 Nevar Married 2 Married | 1 ☐ Yas 2 📉 | | | 2 No | Specify: | o 1110an, ato., | | | III. |
| in in in in in in in in in in in in in i | þ | 3 Widowed 4 □ Divorced | If Yas, Give Yaar or Datas: | | 1 1 1 1 1 1 1 1 1 1 1 | 2121110 | <i>Зреспу.</i> | | Specify | Blac | k |
| 72 hours | Completed | 15. Decedent'a E | Education | 16a. | Decedent's U | sual Occup | pation | | 16b. Kind of Bu | sinass/Ind | ustry |
| Z IZ I D-UUZU d within 72 hours af jiena. r than "netural", or me Heddel Earth | 음 | (Specify only highest gi | | F./\ | lifa. DO NO | work dona Luse ratire | during most of word) | king | | | |
| filed withir Hygiena. ither than | E | Elementery/Secondery (0-12) | College (1-4or : 5 + | 3+) | Teac | her | | | None | | |
| | | 17. Fathar's Nama (First, Middla, Las | () | | | | 18. Mothar's Ner | na (First, Middle | , Maidan Surnam | a) | |
| Wental Mental | Be | Emanuel Hicks | | | | | Flla | Evans | Hicks | | |
| Maryland d2 should be file th and Mental Hy 7 Is marked oth traumatic avent | 2 | 19a. Informant's Name/Ratationship | (Time Brint) | 106 | Malling Adds | ana (Ctuant | and Number or Pu | | | Ctata Tin | Code |
| Mar 12 sho h and h and raum traum | | The second secon | | | | | | | | Stele, Zip | C000) |
| EENL | | Miriam Gallowa | y (Sister | | | | Newtown | | | 01. 70 | |
| Saltimore, semit. Peges 1 at Separtment of Heam Separtment; if Item; in y injury or other size. | | 20a. Method of Disposition 1 Burial 2 Cramation 3 | Removal from State | cemata: | Disposition (/ ry, crematory o | or othar pla | ce) | Data H/15/ | 20c. Location - | City or 10 | MI, Stata |
| nit. Peg antment ortant: Injury o | | 4 □ Donation 5 □ Other (Spec | | Veter | an Cei | mete: | ry | 12/99 | Hurloc | k . Mc | |
| Dealittinor | | 21. Signature of Funaral Service Lice | ensee | | 22. Nama | and Addra | ss of Facility | | 15 1 | | 14.310 |
| D SOFT | | 20 1. B | 8+ - | + | | | Funeral | | M-7 210 | 0.1 | |
| | - | 23a Part I Enter the ricease or over | polications that cause | d the death Do | | | Rd.Sal | | | 01 | Approximate |
| | | 23a. Part1. Entar the disaasa, or cor shock, or haen failura. List only | ona causa on aach li | ne. | | | 19, 000.100 | o. respiratory | | | Intarval Batween Onset and Deeth |
| Physician /Medical | | Immediate Course (Final | | 0 | 0 | | | _ | | 1 | |
| Examiner | | Immediate Ceusa (Final diseasa or condition resulting in daeth) | Cer | eport | 0 | of | ord | | | 16 | 110. |
| | | TOUGHTY IT OLIGITY | | Due to (or as a | consequence o | ng/ | | | | / | |
| D = 2 | Examiner | | Corp | non | 4 | and | 10,7 | dece | ane | - 1 | 40100 |
| be executed sician end burial-transit | Carr | Sequentially list conditions, if any, landing to immediata | | Due to (or as a | ronsequence o | ot): | / | | | 1 | |
| icate be exp physician as the burial | <u> </u> | causa. Entar Underlying | | / | | | | | | 1. | |
| cete be executed physician and the burial-transit | dica | Cause (Disease or injury that initiated evants rasulting in death) Last | С. | Dua to (or as a | consequence of | of): | | | | | |
| J :: | | rasoning in death) Last | | | | | | | | 1 | |
| death certification of for use as | 5 | | d | | | | | | | <u> </u> | |
| To the set of | 8 | Part II. Other eignificant conditions | contribution to doubt b | ust mot consisting in | n the codeshie | i | use in Part 6 | Date Die | tobassa usa sas | Authoria An | the cause of death? |
| that the de by the detached | Physician/M | Part II. Other eignineant conditions | contributing to death b | ut not rasulting a | i tha unoenym | y cause yn | en in Pent I. | | | | |
| | | Diotel en | | | | | | 1 | Yee 2 No | 3 ☐ Prob | ably 4 12 Unknown |
| signe d be | ρ α | | | | | | | 040 14/0 | an autopsy | 24h We | re autopsy findings |
| been sign should be | <u>\$</u> | | | | | | | | ormed? | ava | illebla prior to npletion of causa |
| vical necoration in the control of the contribute has been signed or specificate has been signed or specificate has been signed or specificate has been signed or specificate has been signed or specification or | Completed | | | | | | | | | of c | leath? |
| Tha i | 5 | | | | | | | 10 | Yas 200 No | 1 🗆 | Yas 2□ No |
| delan: The certificate rector, pag | Be | 25. Was casa rafarred to medicel axaminer? | | | | | 26. Place of Dec | ath (Check only | ona) | | |
| Physician: this certific ral director, | 0 | 1 Yas 2 No | Hospitel: 1 Inpatie | ent 2 ER/Ou | tpatient 3 | DOA Oth | ner: 4 Nursing H | loma 5 □ Ras | idance 6 Oth | ar (Specify | ,) |
| Physical distriction | | 27. Mannar of Death | 28a. Data of Inju | | Time of | 28c. Inju | | * | how injury occurr | | |
| or Attending I after death. Director: After din by the fune | 9 | 1 ☐Naturel 5 ☐ Pending 2 ☐ Accident invastigation | (Month, Da | y rear) | njury M | | Yes 2 □ No | | | | |
| Attend ar death ector: by the | 20 | 3 Suicide 6 Could not | 28a Place of Ini | ury - At homa, fe | rm street fac | tory office | | 28f. Location | (Street and Numb | er or Aura | l Routa Number |
| or Attance after death Director: | Certification: | 4 Homicide | | c. (Specify) | , | , | | | wn, Stata) | | |
| 9970 | | 20a Cartifice | hustalan Tarah I | al mortano de d | doubh | a al - a ab a | | | | | |
| 2 2 2 E | 20 | (Check only 2 Medical Exa | hyelclan: To the best miner: On the basis o | examination an | , daarn occurr d/or investigati | ed at tha tir ion, in my d | ma, data and place opinion, death occu | , and dua to the rred at the time | cause(s) and ma , date and place, e | nnar as st and due to | ated. tha cause(s) |
| Hospital 24 hours a Funeral I itely filled | * | one) | and mannar st | ated. | | | | | | | |
| the Hospital hin 24 hours the Funeral apletely filled | _ | OOL Classics and date of the | -75 | | | 29c. Licens | se number | .0 | 29d. Date signed | (Month, I | Jay, Year) |
| To the Hospit within 24 hour To the Funera Completely fill | _ | 29b. Signatura and titla of certifier | 1// | | | - | and the same | | | | |
| Hospi 4 hou Funer tely fill | _ | 29b. Signatura and titla of certifier | MI | | | 0 | 2934 | 9 | 4/12 | 199 | 2 |
| To the Hospit Within 24 hour To the Funer Completely fill | × | 29b. Signatura and titla of certifier 30. Nama and addrass of person who | completed causa of d | leath (Item 23a) | (Type, Print) | 0 | 2934 | 9 | 4/13 | 199 | ? |
| To the Hospit within 24 hour To the Funer To the Funer Completely fill | × | 22A | completed causa of d | leath (Item 23a) | (Type, Print) | Deal | 2934 Howau | Dr. S | alishu | 199 N N | Pa1804 |
| To the Hospit within 24 hour To the Funer To the Funer Completely fill | 8 | 22A | obins, m | leath (Item 23a) | (Type, Print) | Deleat | 2934 Howay | Dn S | alisbu | 199 ry M | Pa1804 |



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | | | Death | | R | eg. No. | | 3420 |
|-------------|--|----------------|---|--|------------------------------|-------------------------------|--------------------------------------|----------------------------------|--|--------------------------------------|------------------|---------------------------------|------------------------------|---|
| П | Physic | an | Decedent's Neme (First, Middle, La. | | | | | | | 2. Dete o | | Dey | Yeer | 3. Tima of Death |
| | /Medi | | MARILEE E. CARRO | | | | | | | APR | | 13, | 1999 | 2:50 AM |
| | Exami | ner | 4a. Fecility Neme (If not institution, giv | A STATE OF THE PARTY. | | | | | 4b. City, Town, | | eath | 4c. County | | |
| _ | | | CIVISTA MEDICAL 5. Sociel Security Number 6. S | | e (In yrs. iest | h leth do ci | If Unda | r 1 Vaar | LA PLA | | f Diete | | RLES | (0) |
| | Funeral Director | | | □M 2X F 4: | | Yrs. | Months | Days | | lin. 8. Dete o | Dey, | Year) 1955 | Counti | LCA (State or Foreign Y) LAND |
| | show | 7 | 10a. Stete 10b. County | | 10c. City, To | | cation | | | | | | 10 | d. inside City Limits |
| | he M | Director | MARYLAND CHARLES 10e. Street end Number | 5 | NANJ | EMOY | 101 71 | 0-1- | | | 4 | 0- 0 | | |
| | 23a or | rai Dir | 8730 SPECIAL PLACE | E | | | 10f. Zip | 206 | 62 | | | 0g. Citizen of V UNITED | | • |
| 020 | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e4 show other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Merital Status 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced | 12. Was Dacedant E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Giva Yeer or Detas: | | | Ves Deced i Yes, sped I □ Yes | | Hispanic Origin? ben, Mexican, Pu Specify: | (Specify Yas o Jerto Rican, atc. | r No- | | e - Amarica ok, White, e | tc. |
| 215-0020 | thin 72 ho e. nn "natur Nedical | Completed | 15. Decedent's En (Specify only highest grant Elementery/Secondery (0-12) | | +) | 6a. Deced (Giva life. L | lent's Usu kind of wo DO NOT u | el Occu ork done se retire | pation during most of ad) | working | | 16b. Kind of Bu | usiness/Indu | ustry |
| 7 | ygian t th | Co | 11TH GRADE | | | EXPL | OSIVE | WO. | | | | GOVERNI | | |
| Maryland | tal H d oth | Be | 17. Father's Neme (First, Middla, Last) | | | | | | -1-27 | Neme (First, Mi | | | (0) | |
| 2 | should and Men america | P | COLBERT DENT | | | | | | | RUTH C | | | | |
| Ma | d2st h and r is n traun | | 19e. Informant'e Neme/Reletionship (| | | | | | t and Number or PLACE, i | | | | | 20de) 1662 |
| | 1 and Haalth em 27 | | JOHNNIE N. HART / | HUSBAND | 20b. Plece | | | | | Dete | | 20c. Location - | | |
| 0 U | | | 1 Burial 2 ☐ Cremation 3 ☐ | | | | | | | | | | | |
| altimore, | 구두주구 | | 4 Donetion 5 Other (Specifical Service Licenters) | | Mr. H | 7 | | | CHURCH ess of Fecility | 4/16/9 | | NANJEMO | Y, MA | RYLAND |
| Ba | Depa Impo any It | | Aldia C. THORN | TON JOHNSON | | 83 34 | 439 I | IVI | | ROAD, I | NDI | AN HEAL | , MD | 20640 |
| | Physician | | 23a. Part1. Entar the diseese, or com shock, or heert feilura. List only | olications that causad one ceuse on eech lin | the death. D | o not ante | ar tha mod | da of dy | ing, such es card | diac or respireto | ory erre | est, | | Approximete Interval Between Onaat and Death |
| | /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in deeth) | e. AMYOTROI | PHIC L | | | | OSIS | | | | 1 | 0 YEARS |
| | ₽ ≈ | ner | | RESPIRA | 0.00 | | | | | | | | 1 | 0 YEARS |
| | and trans | Examiner | Sequentially list conditions, | D. ———— | Due to (or es | | - | | | | | | | |
| 80, | be ex cian s | | Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initieted avents | THROMBOI | EMBOLI | SM | | | | | | | | 4 YEARS |
| 68760, | rificata be executed ng physician and as the burial-transit | Medical | thet initieted avents resulting in death) Lest | | Dua to (or es | e consequ | uence of): | | | | | | 1 | |
| Вох | death cert e attendin ed for usa | Physician/N | | d | | - | | | | | | ··· | ! | |
| 0. | 0 0 0 | sici | Part II. Other significant conditions of | ontributing to death bu | t not resulting | g in the ur | nderlying | ause gi | iven in Pert I. | 23b. | Did to | bacco use co | ntribute to | the cause of death? |
| a | requires that the despensioned by the a | by Phy | DIABETES MELLITUS | ANEMIA | | | | | | - | 1 🗆 Y | es 2⊠No | 3 Probe | ably 4 Unknow |
| Records, | aw requi | Completed | - | | | | | | | 24e. | Wes a | n autopsy ned? | eval | e eutopsy findings lable prior to pletion of cause eath? |
| | 0 - 0 | Con | | | | | | | | | 1 🗌 Ya | s 2 No | 10 | Yes 2□ No |
| Vita | ician: Th cartificata rector, pa | Be (| 25. Wes case referred to medical examiner? | | | | | | | Deeth (Check o | n/y on | e) | | |
| 5 | Physic this ca al dire | 70 | 1 ☐ Yes Ž O ŽNo | Hospitel: 1 inpatiar | | Outpatien | | JA | | g Home 5□I | _ | | | |
| Division of | far | ation: | 27. Menner of Deeth \[\sum_{\text{Netural}} \] 2 \[\] Accident \] 2 \[\text{Netural pending investigation} \] | | Year) 28t | o. Time of Injury | M 2 | 28c. Inju Wo 1 □ | ryat ork?]Yas 2∐ No | 28d. Desc | ribe ho | w Injury occur | red | |
| DIVIS | tal or Attendii rs aftar daath. al Director: A led in by tha fu | Certification: | 3 Suicide 8 Could not be 4 Homicide determined | 28e. Plece of Inju- building, etc. | ry - At home, . (Specify) | ferm, stre | eet, fector | y, office | | 28f. Locati City o | on (St r Town | reet and Numb , Stete) | er or Rural | Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical | 29e. Certifier 1 Certifying Ph | ysician: To the best of iner: On tha bests of and manner stet | exeminetion i | lge, deeth and/or inv | occurred restigetion | et the ti | ime, dete end pli opinion, deeth o | ece, end due to courred et the ti | the ca | use(s) and me ete and piece, | enner as sta and due to t | ted. the cause(s) |
| | To the vithin 2 To the comple | M | 29b. Signature and title of certifier | -1 | 181 | 1 | 290 | c. Lican | sa number | | 2 | 9d. Data signe | d (Month, D | ay, Year) |
| | | | Samo | necke | NA | ww. | | D-0 | 8370 | | A | PRIL 13 | 3, 199 | 9 |
| | | | 30. Name and address of person who of PAUL E. PRITCHETT | | eth (Item 23e | | | FNI I | E P | O. BOX |] 3 | 17 T.A T | PLATA. | MD 20646 |
| T | Sta | te | 31. Date filed (Month, Dey, Year) | 32. Registre | | | -mar 2.1 V | | | | | | | |



| | | State of Maryla | | | of Death | | Reg. No. | 13421 |
|--|--|---|-----------------------------------|--------------------------------|--|--------------------------------------|------------------------------------|---|
| F4 | 1. Decedent's Name (First, Middle, Li | nst) | | | | 2. Date of De | eth Dey | 3. Time of Death |
| Physician /Medica | Helen Tracer | Harris | | | | 4 - | | |
| Examine | 4a Facility Neme (If not institution, gi | | | | 4b. City, Town, or L | ocation of Deat | , | |
| | Atlantic Genera | | 1 - 11 - 1 | if Under 1 | Berlin Year If Under 24 Hrs. | 0 D-1(D: | | ester |
| Funeral Director | 213-24-2399 | Sex 7. Age (In yr | rs. last birthday, Yrs. | | Deys Hours Min. | 8. Dete of Bir (Month, Da) 9/25/0 | | 9. Birthplace (State or Foreign Country) Maryland |
| 20 20 after death with the Maryland or items 23a or 28a-f show critics must be notified at | Usuel Residence of Decedent 10e. State 10b. County | 10c. | City, Town or L | ocation | | | | t0d. Inside City Limits |
| 99 690 nr the Marylan | Md. Worce | ester | Snow | Hill | | | | 1√2 Yes 2 No |
| y q q q o q W death with the Maryland ms 23a or 28a-f show thrust be notified at | Md. Worce | | | 10f. Zip C | ode | | 10g. Citizen of V | Vhet Country? |
| 4 / 9 / 9 / 9 / 9 | | et | | | 21863 | | U.S. | |
| > 4 | 205 Purnell Stree | 12. Wes Decedent Ever in Armed Forces? | U,S. 13. | Was Deceder if Yes, specify | nt of Hispanic Origin? (Spy Cuben, Mexican, Puerto | pecify Yes or No o Rican, etc.) | - 14. Rac Bled | e - American Indian, k, White, etc. |
| 5 07 → 5-0020 T2 hours after netural; or the occal Examina | 1 Never Merried 2 Married 3 Widowed 4 Divorced | 1 Tes 2 No If Yes, Give X Yeer or Dates: | - 13 | t ☐ Yes 25 | No Specify: | | Specify | white |
| 4.0.0.€ | | ducation | t6e. Dece | dent's Usuel | Occupation | | 16b. Kind of Bu | usiness/Industry |
| 215 215 215 | (Specify only highest gr | Coilege (1-4or 5+) | (Give | kind of work DO NOT use | done during most of wor | king | | |
| 4 2 2121 d within giene. | 15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) | College (1-401 34) | cler | rical | | | | nce Business |
| and 2 | 17. Fether's Neme (First, Middle, Las | | | | 18. Mother's Nen | | | |
| CP Z Page 4 | Thomas Francis | | | | | le Powel | | rader) |
| 7) ~ = 0,22 | 19e. Informent's Neme/Reletionship | | | | Street end Number or Ru | | | |
| V-1 V-1 I Health Themstr | Mrs. Mildred Ja 20a. Method of Disposition | ackson (niece) | 205 Plece of Disp | Purnel | 1 St., Snow | Hill, | | City or Town, Stete |
| N CO O STEP | N Burlel 2 □ Cremation 3 | Removel from State | cemetery, cre | metory or oth | er place) | | | 11, Md. |
| | 4 Donetion 5 Other (Special Service Lice | | | | Cemetery 4 | | | |
| Harr Baltin | Wat - | +Mar | | | Funeral Hom | P.C | Box 87 | 7 1d 21863 |
| | 23a. Part1. Enter the disease, or con | nplicetions that caused the de | w | | | | | Approximate Intervel Between |
| Physician | shock, or heert feilure. List only | y one cause on each line. | | | 0 | | | Onset and Deeth |
| /Medical | Immediate Ceuse (Final disease or condition | ASPIR | ATIC | DXL | Prec | enca | 74 | 1 fan |
| Examiner | resulting in deeth) | e. Due to | (or es a conse | quence of): | - N - | -0 | | |
| D = | Sequentially list conditions, if any, leading to immediate cause. Enter I before light of the cause of the ca | INTE | STZ | DAL | OBS | TREE | ZZOX | 3 3 day |
| 60, be axecuted iclan and bunal-transi | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to | (or es e conse | quence of): | | | | |
| pring & e | Ceuse (Diseese or Injury | C | | | | | - | |
| 587 icate phys | | Due to | (or as e conse | quenca of): | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be asscuted the has been signed by the attending physician and page 2 should be detached for usa as the bunal-transit | Pert II. Other eignificant conditione | d | | | | | | |
| . B. | Pert ii. Other eignificant conditione | contributing to death but not i | esulting in the | underlying cau | use given in Pert I. | 23b. Did | tobacco use co | ntribute to the cause of death? |
| O. O. Dy the tache | À L | | | | • | | Yes 200 | 3 Probably 4 Unknown |
| S tha | 6 | | | | | | | |
| cord v require should is | | | | | | 24e. Wes | en eutopsy ormed? | 24b. Were eutopsy findings eveilable prior to completion of cause |
| law ras be | | | | | | | | of deeth? |
| The It | | | | | | 1 🗆 | Yes 2 No | 1 ☐ Yes 2 ☐ No |
| Vital Relations The law | 25. Wes case referred to medical examiner? | Hospitel: | | | 26. Place of Dec | eth (Check only | one) | |
| of hysi | 1 Yes 20 No | 28e. Dete of Injury | ☐ ER/Outpatie | | | 1 | how injury occur | |
| After funer | Neturel 5 Pending | (Month, Dey Year, | | M 201 | c. Injury at Work? t ☐ Yes 2 ☐ No | ZOG. Describe | now injury occur | 100 |
| Division of Vital Records, or Attanding Physician: The law requires tha flactdath. Director: After this cardificate has been signed in by the funeral director, page 2 should be to the funeral director. | 3 Suicide 6 Could not | be 28e. Plece of Injury - A | home, ferm, s | treet, fectory, | | 28f. Location | Street and Numl | per or Rural Route Number, |
| Div after Dire | 4 Homicide | building, etc. (Spe | oity) | | | City or To | wn, Stete) | |
| | 29a. Certifier Certifying P | hyeician: To the best of my k miner: On the basis of exemi end menger steted. | nowledge, dee netion end/or in | th occurred et | the time, dete end plece n my opinion, deeth occu | , end due to the rred et the time | ceuse(s) end me dete end pieca, | enner as stated. and due to the cause(s) |
| rithin outh | 29b. Signeture end title of cartifier | n // | _, | 29c. | License number D26 | 5040 | 29d. Dete signe | d (Month, Day, Year) |
| - SFO | > // | 1) & THE | 8419K | FI) | 12009 |) | 4 | 191991 |
| | 30. Neme end eddress of person with | commented at the of deeth (I | tem 23e) (Type | , Print) | | | 4 | ur ! |
| 11 | Craig Schaefer, | 7 1/1 | | | ve, Salisbur | y,Md. 2 | 1801 | |
| State | 31. Dete filed (Month, Day, Yeer) | 32. Pegistrer's Sig | | 1 | | | | |
| Registra | HPK I 4 1 | 999 Semen | 6. | 400 | elent | | | |

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Registrar

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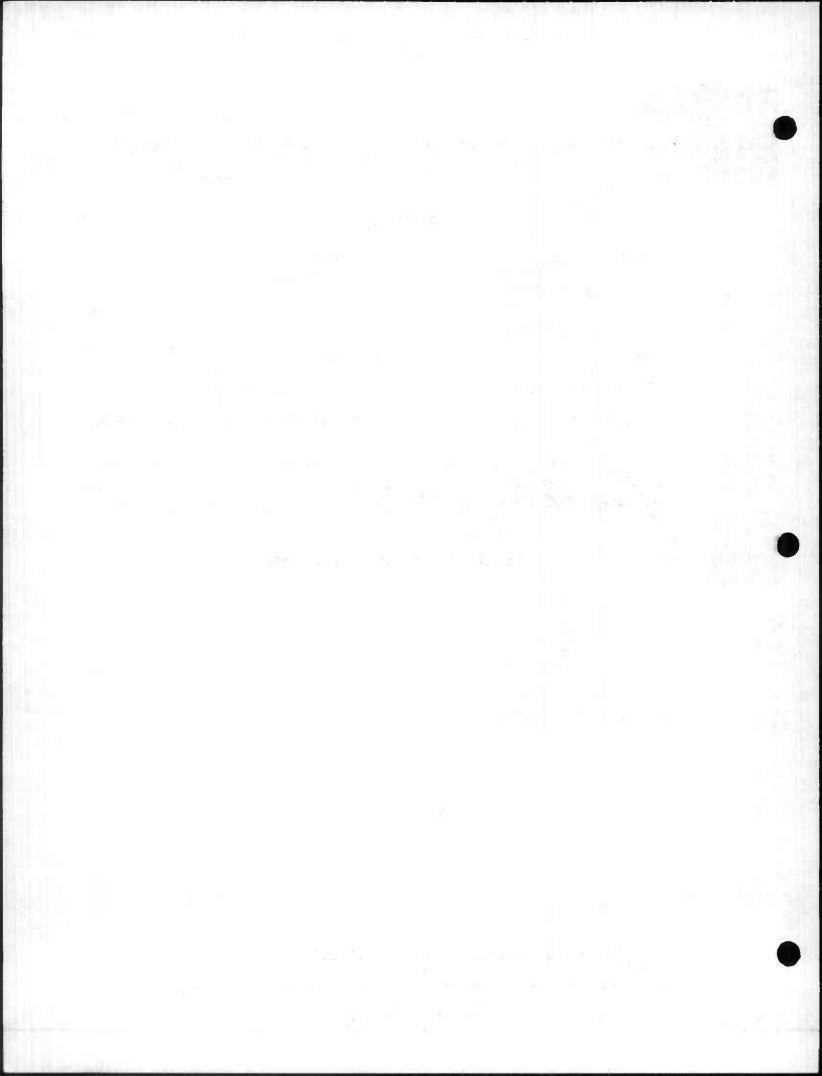
| | | | | | Cer | tificate of | Death | | Reg. No. | | 0466 |
|--|----------|---|---|--|-----------------------------|---|---|---|------------------------------------|------------------------------------|---|
| Physician | | 1. Decedent's Name (First, Middle | ce Heil | in | | | | 2. Dete of De Month | Dey | Year | 3. Time of Deeth |
| /Medical | ı | 4e. Facility Nema (If not institution | | 0 | | | 4h Cihi Toum | MARCI or Location of Deal | . 1 | 1999 | 1805 |
| Examiner | | PENINSULA RE | | | ENTER | | | SBURY | | y of Deeth COMICO |) |
| Funeral | 1 | 5. Social Sacurity Number | 6. Sex | 7. Age (In yrs. le | | If Under 1 Year | If Under 24 H | rs P Date of Di | 4h | 9. Birthpi | ieca (Stata or Forei |
| Director | 4 | Usual Residence of Decadent | 1□ M : 3/2 F | 66 | Yrs. | Months Deys | Hours Mi | March | 1, 1933 | Wash | ington, |
| or 28a-f show | 0 | Virginia 10b. County Acc | romack | | town or Lo | | | | | 10 | 0d. Inside City Lim Yes 2□ |
| effer death with the Maryla or Neme 23s or 28s-1 sho marer must be notified at Funeral Director | מו | 10e. Street end Number 24190 Bennett | Street | | | 10f. Zip Code 23421 | , | | 10g. Citizen of | What Count | try? |
| be lied within 72 nouts etter death with the Maryland tal Hygiene. Ital Hygiene. d other than "naturel", or Items 23s or 28s-f show event, the Medical Examiner must be notified at 80 millior of 10 m | 5 | 11. Maritel Stetus 1 Nevar Marriad 2 Marr 3 Widowed 4 Divorcad | Armed F | 2 No ive | H | Vas Decedent of i Yes, specify Cub | en, Mexican, Pue | (Specify Yes or No erto Rican, etc.) | | ce - America ck, White, e y: | etç. |
| permit. Peges I and 2 should be lied within 72 hours. Department of Health end Mental Hygiene. Department of Health and Mental Hygiene and Informant: If Item 27 Is marked other than "naturel", ceny Injury or other traumetic event, tre Medical Exagines. To Be Completed by | on block | 15. Decadent (Specify only highes Elementary/Secondary (0-12) | it grade completed) | (1-4or 5+) | (Give | lent's Usuel Occu kind of work done OO NOT use retire | during most of w | rorking | 16b. Kind of B | | |
| Mental Hy Mental Hy artic event, artic event, | | 17. Father's Neme (First, Middle, Unavaila | lest) | | | | 18. Mather's N | ame (First, Middle | Maiden Sumer | na) | |
| and z should saith end Men n 27 is marke ier traumatic | | 19e. Informent's Name/Relations Robert Heilog S | | N. C. C. C. C. C. C. C. C. C. C. C. C. C. | | g Address (Stree | | Rural Route Numb | | 9 | Code) |
| permit. Peges 1 a Department of He Important: If Item eny Injury or othe ODGE. | | 20a. Method of Disposition 1 Burlel 2 Cramation 4 Donation 5 Other (St | | State Cer | netery, crem | sition (Name of natory or other ple | | Dete | 20c. Location | 4.0 | |
| Departr Imports eny inju | | 21. Signeture of Funerel Service I | Licansee | 200 | 0 3 | Nama and Address | ess of Fecility Ho | me. | | 0 | - |
| | 1 | 23e. Part1. Entar the diseesa, or shock, or heart failure. List | complications thet | causad the death. | Donot ente | rthe mode of dy | ng, such es cardi | rginia 25 ec or respiretory e | rrest, | | Approximete |
| hysician | 1 | orton, or rioart landro. List | orny one decise on | becit iiile. | | | | | | | fntervel Between Onset and Deeth |
| /Medicai Examiner | | Immediate Ceuse (Finel disease or condition resulting in death) | e. A | deno ca | rein | ona c | of Lu- | 19 | | | 1 year |
| je je | | | | Due to (or | es e conseq | uence of): | | | | | |
| g physician end es the buriel-transit | | Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury | b | Due to (or e | es e consequ | uenca of): | | | | - | |
| ling physicia ie es the buri | | Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest | c | Dua to (or e | s e consequ | uanca of): | | | | | |
| ettend for us | | | 0 | | | | | | | | |
| been signed by the ettendin should be detached for use | | Pert II. Other significant conditio | ns contributing to d | eath but not result | ing In the un | derlying cause gi | ven in Pert I. | | | | the ceuse of deal |
| | | | | | | | | 24e. Wes | an autopsy ormed? | eve | ore autopsy finding pileble prior to applation of cause deeth? |
| sistements of the second director, page 2 | | | | | | | | 1 🗆 | Yes 200 | 1 🗆 | Yes 2 No |
| certific ractor | | 25. Wes case referred to medical exeminer? | Hospitel: | _ | | Ot | hor | eeth (Check only | | | |
| 5 0 0 | - | 1 Yes 25 No 27. Menner of Deeth | 134 | | R/Outpetient 8b. Time of | 00000 | | Home 5 Resi | dence 8 Oth | |) |
| or death. ector: After this certificity the funeral director, fication: To Be (| | 1 Sending 2 Accident 5 Pending investig | | of Injury 2 th, Dey Yeer) | Injury | 28c. Inju Wo M 1 | rk?` IYes 2∐No | 200. 2000.100 | now injury occur | 100 | |
| rs after death. Is after death. In Director: After the death of the funeral death. Certification: | | 3 Suicide 6 Could n 4 Homicide determi | ned 286 Place | of Injury - At homing, etc. (Specify) | e, farm, stre | et, fectory, office | | 28f. Location (City or To | Street end Num t wn, Stete) | per or Rural | Route Number, |
| White 24 hours after death. To the Funerel Director: After this completely filled in by the funeral Medical Certification: 1 | | 29a. Certifier 1. Certifying (Check only one) 2 Medical E | Phyeician: To the examiner: On the b | best of my knowle esis of exemination oner steted. | edge, death n end/or inv | occurred et the ti estigetion, in my | me, dete end plea opinion, deeth occ | ce, end due to the curred et the time, | ceuse(s) end mo date end plece, | end due to | eted. the cause(s) |
| within To th comp | | 29b. Signater arts title of certifier | 2/2 | nec | 2. | 29c. Licans | sa number | | 29d. Date signe | | |
| 200 | > | 30. Name and address of person v | who completed caus | se of deeth (Item 2 | 3e) (Type, F | Print) | 54. | 5-1:, 50 | -, N | 1 D . | |
| State | 2 | 31. Dete filed (Month, Dey, Yeer) | | Registrer's Signatu | re. | | | | / / | | |
| Registrar | | APR 0.2.1 | | enered | 5 | Spark | 2 | | | | |
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| | | | | | Certifica | | Death | | Reg. No. | 4 5 | 1960 |
|---|--------------------|---|--|----------------------------|--|---------------------------|---|------------------------------------|------------------------------------|------------------------------------|---|
| Physi /Med | | Decedent's Neme (First, Middle, Las ROBERT | υ J. | | НАУГ | FN | | 2. Dete of De Month | Dey | Yeer 99 | 3. Time of Deeth |
| Exam Funera Directo | iner | 4e. Fecility Neme (If not institution, give PENINSULA REGIONA) 5. Sociel Security Number 6. Se 403–68–6488 | street and number) | CENTE (In yrs. last) | R birthday) If Und Month | er 1 Year | 4b. City, Town, or L SALISBURY If Under 24 Hrs. Hours Min. | | WICON rth ay, Year) | of Death VICO 9. Birthple Count | ece (State or Fore |
| | | Usuel Residence of Decedent 10a. Stete 10b. County | | | own or Location | | | 103-14- | 40. | Kentı | - |
| Manyle f shor | 6 | Maryland Wicomic | ~ | | lisbury | | | | | 10 | ld. Inside City Lim 1 Yes 2 □ I |
| T 28a | Director | 10e. Street end Number | .0 | 50 | - | ip Code | | | 10g. Citizen of \ | Whet Count | ry? |
| h wit | | 32144 Huntley Cir | ccle | | | 218 | 04 | | USA | | |
| Nary land 21215-UUZU 2 should be filed within 72 hours efter deeth with the Marylend end Mental Hygiene. Is marked other than "natural", or frems 23s or 28s-f show sumatic event, it a Medical Examination must be notified at | by Funeral | 11. Maritel Status 1 Never Married 2 Nerried 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes: | | 13. Wes Dec | edent of t ecify Cub | Hispanic Origin? (Speen, Mexican, Puerto Specify: | pecify Yes or No Rican, etc.) | o- 14. Rac | e - America ck, White, e | ic. |
| ire, Maryland ZIZI3-UUZU s 1 end 2 should be filed within 72 hours ef if Health end Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, its Medical Exert | Completed | 15. Decedent's Edi (Specify only highest gred Elementary/Secondery (0-12) | | +) | Ge. Decedent's Us (Give kind of v life. DO NOT District | rork done use retira | during most of work id) | sing | 16b. Kind of B | usiness/ind | ustry |
| Hyg other | Be | 17. Fether's Name (First, Middle, Last) | | | DIDOLICO | | 18. Mother's Nem | e (First, Middle | , Maiden Suman | ne) | |
| should be filed of Mental Hyginmarked other | ToB | William Clark Ha | ayden | | | | Beula | h Roll | in | | |
| re, Maryland 1 end 2 should be file Health end Mental Hy em 27 is marked othe | | 19e. Informent's Neme/Relationship (T Mary Lee Hayden) | | | | | and Number or Rui y Circle, | | | | |
| Dail(Imore, N permit. Pages 1 end Department of Heaith Important: If Item 27 any injury or other tr | | 20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 10 Other (Specify, | Removel from Stete | ceme | of Disposition (Nitery, crematory of | other ple | Mausoleum | Date 4/13/99 | 20c. Location - | | |
| Physician /Medica Examine | | Immediate Cause (Final disease or composition) and the control of | e. HYPERTE |) NSIVE | HOLIC 501 S to not enter the ma | way now_ ode of dyi | ess of Fecility Funeral H Hill Rd., ng. such es cardiac AR DISEAS | Salish or respiretory e | ury, MD | 21804 | |
| death certificate be executed ettending physicien and of for use es the buriel-transit | n/Medical Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that inflieted events resulting in death) Lest | c | | a consequence of | | | | | 1 | |
| deeth deeth ed for | sicia | Pert il. Other aignificant conditions co | ntributing to death bu | it not resulting | in the underlying | cause gi | ven in Pert I. | 23b. Did | tobacco use co | ntributa to | the cause of dea |
| es that the de signed by the e | by Physician/M | CONGESTIVE HEART | FAILURE | | | | | 1 🗆 | Yes 2□No | 3 Prob | ably 4X Unknown |
| requir | Completed b | | | | | | | | s an autopsy ormed? | ave | re autopsy finding llable prior to apletion of cause eath? |
| - W (0) | Con | | | | | | | 10 | Yes 2 No | 1□ | Yes 2□ No |
| Or VICAL MEDIA Physicien: The law this certificate hes is | Be | 25. Wes case referred to medical examiner? | Hospitel: | | | Ott | 26. Plece of Deel | | | | |
| Ing Pt | itlon: To | 1 XYes 2 No 27. Menner of Death 1 XNatural 5 Pending 2 Accident investigation | 1 ∐ Inpatier 28a. Dete of Injur (Month, Day | | Outpetient 3 [| 28c. Inju Wo | TE HOUSING TO | | Idence 6 □Oth how Injury occur | |) |
| LIVISION I or Attending efter death. Director: After d in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inju building, etc. | ry - At home, (Specify) | ferm, street, facto | ory, office | | 28f. Location (City or To | (Street and Numb wn, State) | er or Rural | Route Number, |
| To the Hospital or Ati within 24 hours effect To the Funeral Direct completely filled in by | edical C | 29a. Certifier 1 Cartifying Phy (Check only one) 2 Medical Exami | sician: To the best of ner: On the basis of end menner stat | examinetion e | ge, deeth occurre end/or investigation | d at the ti | me, date end plece, opinion, death occur | end due to the red at the time, | cause(s) and ma dete end place, | inner as sta and due to | ated. the cause(s) |
| To the within 2 To the comple | Me | 29b. Signature end title of certifier | | | 2 | 9c. Licens | se number | | 29d. Date signe | d (Month, E | Day, Year) |
| | | ColuCZ | Bull: | nales | 1.E. I | 00003 | 3599 | | 04-06-9 | 9 | |
| <i>3</i> | | 30. Name and address of person who of JOHN T. BULKELEY, | | |) (Type, Print) | 507,20007,0 | SALISBURY | יני חוא ז | | 2 | |
| S ¹ Regis | tate trar | 31. Date filed (Month_Day, Year) | 32. Registra | r's Signature | | lon. | | _ LIL (LL) | OOT | | |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month **Physician** Ann Margaret Heilman 9:40 PM 1999 ADRIL /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BAITIMORE CenTer tospila Kose QUAKE dAle FRANKLIN If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Yaa April 10, If Undar 1 9. Birthplaca (Stata or Foraign Country) Pennsylvania 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Yaar) Months Days 1□ M 2X) F 1945 165-36-1474 Director Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits liem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Yas 2 No Director Maryland Baltimore Baltimore 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8430 Hallmark Circle 21234 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2XDNo If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married XX Married 1 ☐ Yas 2XXNo Specify: Specify: White Maryland 21215-0020 þ 3 ☐ Widowad 4 ☐ Divorcad 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Spacify only highast grada complated) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "r Collaga (1-4or 5+) Elamantary/Secondary (0-12) Teacher Education 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Edwin James Morgan Alberta Marie Hirt 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Willard C. Heilman, husband 8430 Hallmark Circle Baltimore, MD 21234 altimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Injury or 4 X Donation 5 ☐ Othar (Specify) 4/19/99 Howard U. Coll. of Med. Washington, DC 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licenti Lincoln & Lincoln Funeral Service 4315 Anacostia Ave., NE Wash., DC 20019 ter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, heart lattered. List only one cause on each line. **Physician** /Medicaí Immediata Causa (Final a. InTRACERE BRAL 15 minutes disaasa or condition rasulting in daath) Examiner Examiner MeTASTATIC AngiosAR com A certificate be axecuted physician end s the buriel-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last Dua to (or as a consaquenca of): Box 68760. Physician/Medical Dua to (or as a consequance of): 88 use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen has page 2 2 No 1 □ Yas 2 □ No certificete or Attending Physician: 25. Was casa rafarrad to medical axaminar? Be 28. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) To this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accidant 5 Panding efter death. 1 Tas 2 No invastigation 6 Could not be datamined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homleida 24 hours e Hospital edical 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medicat Exampler: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) 29a. Cartifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cert 29c. Licansa number 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Chacko 9000 FRANKlin Square DR. BAITIMORE, MARYLAND DR. Geo-Philips

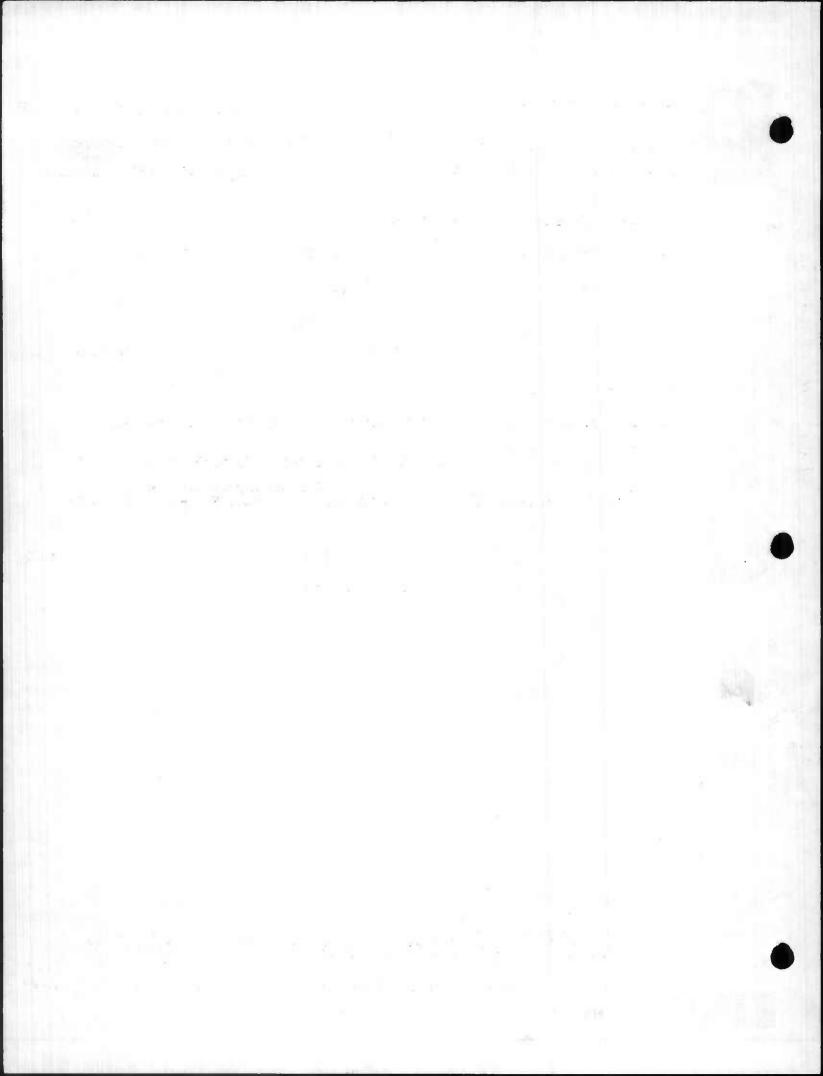
State Registrar 31. Data filed (Month, Day, Yaar)

APR 1 2 1999

32. Ragistrar's Signatura

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| | T. 1000 | | Decedant's Nama (First, Midden | fa, Last) | | Cer | tificate o | Death | 2. Data of De | Reg. No. | | 3. Tima | of Death |
|------------|--|----------------|---|--|------------------|-------------------------------|--|-------------------------------|--------------------------------|-----------------------------------|----------------|---|---|
| | Physic | | Albert Parke | | | | | | Month 04 | Day | Yaar 999 | | 30 An |
| 8 | /Medi Examii | | 4a. Facility Nama (If not Institution | | ber) | | | 4b. City, Town, or | | | | 102 | 307" |
| М | LAGIIII | 161 | 100 Eighth Stre | | | | | Pocomo | ke City | Worce | | | |
| | Funerai | П | 5. Social Sacurity Number | | . Aga (In yrs. | last birthday) | If Undar 1 Yaa | r If Undar 24 Hr | S. 8. Data of Bir | th | | laca (Stati | a or Foreign |
| d | Director | | 212-12-3788 | ₩ 2 F | 8 | 34 Yrs. | Months Day | s Hours Min | 02/05/ | 1915 | Mary | land | |
| П | pud * | | Usual Rasidance of Decedant 10a. Stata 10b. Count | 4 | 10c Ci | ty, Town or Lo | cetion | | | | 1 | Od toolds | Olb . I les la |
| | lanyla sho | ŏ | | | | | | | | | 1 | - | City Limits |
| | 289- | Director | Maryland Worces 10e. Street and Number | ster | Poc | comoke | 10f. Zip Coda | | | 10g. Citizen of | What Cour | | |
| | With Se or | | | . L | | | | \ F.4 | | | William Coun | itry r | |
| | ma 2: | Funeral | 402 Maple Stree | 12. Was Deced | | | 218 Vas Decedant of | Hispanic Origin? (| Specify Yas or No | USA 14. Rad | e - Amaric | an Indian, | |
| 21215-0020 | ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental thygiene. If Hem 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Example must be multiple at | by | 1 ☐ Navar Marriad 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce | If Yas Giva | No 🗹 | 91 | Yas, specify Cu □ Yas 2\(\overline{\Omega}\) No | ben, Maxican, Pua | rto Rican, atc.) | Specif. | ck, Whita, whi | | |
| 2-0 | 72 ho | Completed | 15. Deceda | nt's Education | | 16a. Deced | ent's Usual Occi | pation | ad for | 16b. Kind of B | usiness/Inc | dustry | |
| 21 | lihin 7 | npie | Elemantary/Secondary (0-12) | ast grada complatad) Collaga (1-4 | 4or 5+) | life. L | OO NOT usa ratii | during most of wo | orking | | | | |
| 7 | ygjer ygjer ner th | | 4 | | | Labo | rer | | | Food P | | sing | |
| anc | be fill | Be | 17. Father's Nama (First, Middla | , Last) | | | | | ıma (First, Middla | , Maidan Sumar | na) | | |
| Maryland | d Me mark | 10 | Ernest Jones 19a. Intormant's Name/Ralation | chia (Tuna Print) | | 10b Maltin | a Addraga /Ctra | Cynthia et and Number or F | | na Cita na Taura | Out- W- | 0-4-1 | |
| Ma | Ith an | | Dora F. Jones | (wife) | | | | | | | | , | |
| re, | f Hear term of | | 20a. Mathod of Disposition | (wile) | 20b. I | Place of Dispos | sition (Nama of | reet, Poc | Data CI | 20c. Location | | | |
| 9 | Pege ont o | | 1 X Buria! 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (| | ata | | natory or other pi tist Cen | * | 4/15/99 | Dogomek | o Cit | v. MT | |
| Baltimore, | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Hem 27 is marked other than 'any injury or other traumatic event, the Magnee. | | 21. Signature of Fugaral Sarvice | <u> </u> | <u> </u> | 22 | Name and Add | ass of Facility | | | | .у, ги | <i>y</i> |
| m | Depa Impo | | muchuel 1 | Dean M | 01129 | | _ | Melson F | | | | 051 | |
| | 110 | | 23a. Part1. Entar tha disaasa, o shock, or haart failura. Lis | r complications that can | used tha daa | | | en Ave., | | | וא עוויי | Approxim | ata |
| | Physician | | SHOOK, OF HIGHER TARGET. LIS | | | | | | | | 1 | Intarval B Onsat an | d Death |
| | /Medical Examiner | | Immediata Cause (Final disaasa or condition | COP | 20NA | 4 0 | Dack | SION | | | | MINI | TES |
| В | - Adminion | 70 | rasulting in death) | | Due to (| or as a conseq | uance ot): | C-V | 2 | | | 100 | UTES |
| | ted nsit | Examiner | | b. H4F | | | | C-V | DISE | A-SE | | IEA | 3 |
| -5 | and and al-tra | Exal | Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Disease or Injury | | Dua to (d | or as a consequ | uence ot); | | | | i | | |
| 68760, | ificate be executed g physician and as the burlal-transit | edical | triat initiated avants | c | Due to /o | | innon ott: | | | | | | |
| | E 0 4 | | rasulting in daath) Last | | Dua to (c | r as a consequ | ance ot): | | | | 1 | | |
| Вох | eeth cert | N/ue | | d | | | | | | | | | |
| | law requires that the deeth cert as been signed by the ettendin 2 should be detached for use | Physician/M | Part II. Other significant conditi | ons contributing to dea | th but not ras | ulting in the un | darlying causa g | ivan in Part I. | 23b. Dld | tobacco use co | ntribute to | the cause | e of death? |
| O. | at the | Phy | | | | | | | 10 | Yee 2□ No | 3 Prot | pably 4) | Unknown |
| S, | v requires that the de been signed by the should be detached | þ | | | | | | *** | | | | | |
| Records, | requi | Completed | | | | | | | 24a. Was perfe | an autopsy omed? | ava | are autops allable prio mpiation of | or to |
| 3ec | has t | I I | | | | | | | | | of c | death? | , |
| = | ician: The la certificate ha rector, page | | 00.00 | | | | | | 10 | | 1[| Yas 2 | No |
| Vital | | o Be | 25. Was casa ratarred to medica axaminar? 1 ☐ Yas 2 ☑ No | Hospital: | | LEDIO ALVIEN | | | ath (Check only | | | 400 | 011 61 |
| o | | | 27. Mannar of Death | 28a. Data of | Injury | ER/Outpatient 28b. Tima of | 28c. Inj | 4 LI Nursing | Homa 5 ☐ Rasi 28d. Dascribe | dence 8 240th how injury occur | | 0 100 8 | oth St. |
| Division | Attending For death. | atio | 1 Natural 5 Pendi | 19 | Day Year) | Injury | | ork?]Yas 2.∏No | | | | | |
| N S | if or Attendin after death. Director: Af d in by the fu | Certification: | 3 ☐ Sulcida 6 ☐ Could 4 ☐ Homicide datam | nined 288. Place of | f Injury - At he | oma, tarm, stra | at, factory, office | | 28f. Location (City or To | Street and Numb | per or Rura | Routa Nu | ımber, |
| ۵ | rs afte al Dir | | | Danding | , atc. (opecin | y / | | | Ony or ro | wii, Olalay | | | |
| | To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b | edical | (Uneck only 2 Medical | ng Phyeician: To the be Examiner: On the basi | est ot my kno | wiedge, daath | occurred at the i | ime, data and place | a, and dua to the | cause(s) and me | enner es st | ated. | a/e) |
| | within 2 To the I complet | Med | | and manne | r stated. | | | | | | | | |
| | 5 | | 29b. Signature and title of certific | + | - | 0 | - | sa number | | 29d. Date signa | a (Month, I | uay, Year) | |
| | | | 20 Non-and addition 2 | an | <u> </u> | 0 | | 4556 | | 7/15/ | 79 | | |
| | | 2 | 30. Name and address of person | | | | | | | - 1 | | | |
| | | - | Dr. Jesus Santi 31. Data tilad (Month, Day, Year, | and, M.D. | - 100 | Lighth | St., Po | comoke C | ity. MD | 21851 | | | |

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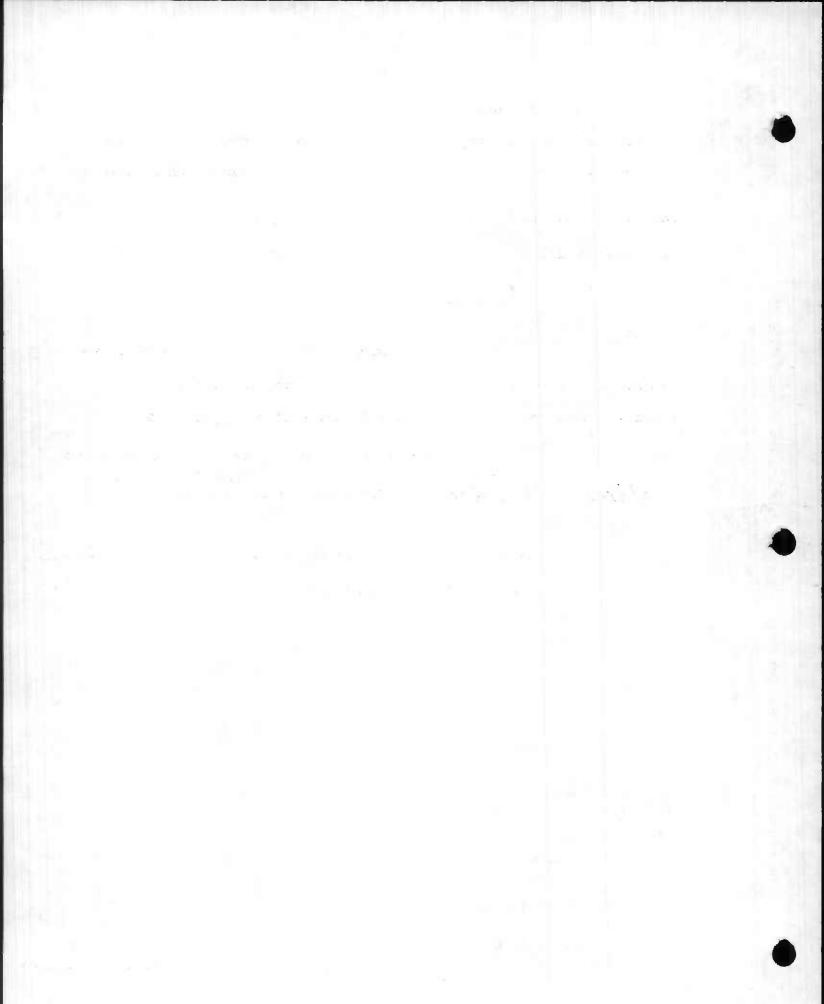
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1 Decedant's Nama (First Middle Last) 2. Dafa of Daath **Physician** 22:17 James Paul Jennings 1999 8, April /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Carroll County General Hospital Westminster Carroll # Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Apr 24,1922 If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (Stata or Foreign
Country) **Funeral** Months Days 120 M 2□ F 578-20-2969 76 Yrs. Washington DC **Director** Usual Rasidance of Dacedant with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. fnsida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examiner must be norified at 1 ☐ Yas 2 No Baltimore Maryland Upperco Directo 10e. Sfreef and Number 10f. Zip Coda 10g. Citizen of Whet Country? 5306 Trenton Mill Road 21155 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after d. Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Modical Experimentals. Black, Whita, atc. 1 □ Yes 2 □ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: White þ 3 ☐ Widowad 4 ☐ Divorced WW II 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Owner Landscape Contractor 18. Mother's Neme (First, Middla, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Robert O. Jennings Sr Virginia Martin 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Carolyn A. Jennings, wife 5306 Trenton Mill Rd, Upperco, Md 21155 altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata 4/9 Hampstead, MD Carroll Cremations 4 □ Donation 5 □ Othar (Spacify) 22. Name and Address of Facility 21. Signatura of Furteral Sarvice Licensaa Eline Funeral Home 934 South Main St, Hampstead, Md 21074 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntarval Batween Onset and Death **Physician** Immediata Ceusa (Final disaesa or condition resulting in deeth) rivieulea . Massive cerebrovascular Accident Examiner Dua to (or as a consequence of): Examiner Bleed Intracerebral physician and the bunal-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Box 68760. Physician/Medical the Due to (or as a consequence of): usa ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wera autopsy findings aveilabla prior to complation of ceuse of daath? 24a. Was an autopsy performed? Completed paga 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cese referred to medical axaminar? Be 26. Placa of Daath (Chack only ona) Hospital: 1 Malinpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No P After this 28e. Deta of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury at Work? I or Attending Patter death.

Director: After i Certification: 1 Metural 5 ☐ Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida 24 hours a Hospital 1🔁 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end due to the ceusa(s) and mannar es stated. 29a. Cartifier edical 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fitla of certifier APRIL, 8, 1999 From frim, m.D D52479 30. Nama and eddrass of person who completed ceusa of death (Itam 230) (Type, Print) LISA Kim, M.D. at Carrell County General 200 memorial Avenue, Westminster, MD 21157 at 31. Data filad (Month, Day, Year) 32. Ragistrar's Signature State

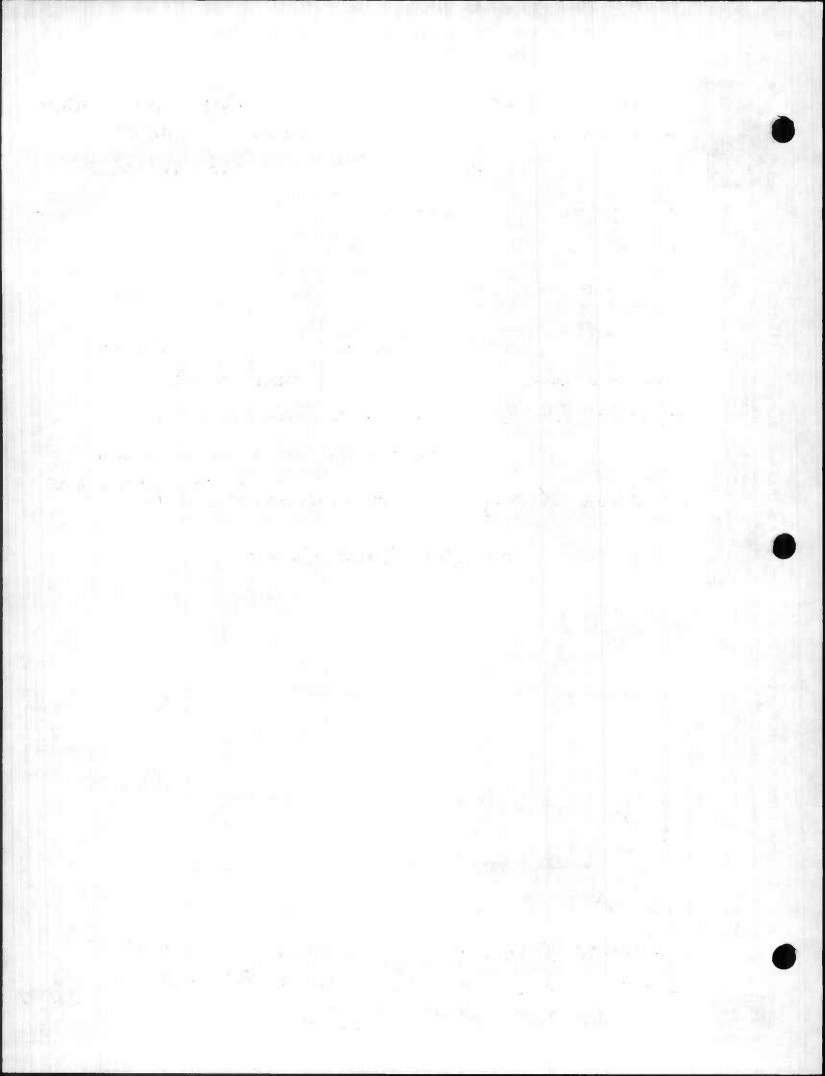
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death

| | | | | | 001 | incate o | Death | | Heg. No. | | |
|--|--|--|---|-------------------------------|------------------------|--|----------------------------------|---------------------------------------|---------------------------------|-------------------------------------|--|
| Physician //Medical | 1. Decedent's N Barba | ama (First, Middla, I ra Ann | | | | | | 2. Data of D Month April | 8 Day 199 | 9 ^{Year} | 3:30am |
| Examiner | | e (If not institution, g | give street and numbe | er) | | | 4b. City, Town Sykes | or Location of Des Ville | 4c. County Carr | of Death | |
| Funeral Director | 5. Social Securit 034-42- | | | Aga (In yrs. Ia 45 | st birthday) Yrs. | If Under 1 Year Months Day | | | inth Year) 1953 | 9. Birthy Mass | olaca (Stata or Foraign htry) |
| pu & | Usual Residence | of Decedent 10b. County | | 10c City | Town or Lo | cetion | | | | 1. | 0d. inside City Limits |
| r 28a-f show | Md | Carroll | | Syk | esvil | le | | | | | 1 ☐ Yas 2 X No |
| th with the Mai 23a or 28a-f si unt be notified al Director | 10e. Street and 304 Nea. | Number le Court | | | | 10f. Zip Code 2178 | | | 10g. Citizen of USA | Whet Cour | ntry? |
| ter dee Items Inst. m | | arried 2. XMarried d 4 □ Divorced | 12. Was Deceder Armed Force 1 Yes 2 If Yes, Giva Year or Dates | s? Ø No | | Vas Decedant of Yes, specify Cu | | ? (Specify Yes or Nuerto Rican, atc.) | Bla | ce - Americ ck, White, v:Whit | |
| 72 hours "natural", soliral Ex- | | 15. Decedent's | Education | - | 18a. Deced | lent's Usual Occ | upation | | 16b. Kind of B | usiness/In | dustry |
| led within 72 hours af Vgjena. Per than "natural", or rt, the Moulcal Enan Completed by F | | pecify only highest g econdary (0-12) | completed) College (1-40 | or 5+) | life. L | kind of work don DO NOT usa reti homema.ke | | working | dome | estic | |
| should be flied within and Mental Hygiena. marked other than armatic event, the M | | ne (First, Middle, La dward Car: | | | | | | Name (First, Middicional Ann | | ne) | |
| ges 1 and 2 should be filed to 4 filed be filed to 4 filed by the file | 19a. Informant's Michael | Name/Relationship Kmon (hi | (Type, Print) usband) | | 19b. Mailin 304 No | g Address (Stre | et and Number o | or Rural Route Num Sville, M | ber, City or Town, | , State, Zip | Code) |
| Heel Heel other | 20a. Method of I | Disposition | | 20b. Pla | ce of Dispo | sition (Name of | ale and | Dete | 20c. Location | - City or To | own, State |
| Peges ent of tr: If it | | 2X☐ Cremation 3 on 5 ☐ Other (Spec | ☐Ramoval from State | te Carr | oll C. | remation | Serv. | 4-8-99 | Hampstea | ad, M | D |
| permit. Peges 1 and 2 sho Department of Heelih end Important: If feen 27 is and eny injury or other traum blice. | | Funerel Service Lic | ensee | | 22 | . Name and Add | fress of Facility | Haight F | uneral Ho | ome & | Chapel |
| 20500 | NO | lian C | X. Houge | | | | | esville, | | 4 | |
| Physician /Medical Examiner | Immediate Caus disease or cond resulting in deat | se (Final | an entire that be used to the second | tastas | | Breast | Cance | | | | Interval Between Onset and Death |
| axecuted in and ial-transi | Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ave | conditions, o immediate | b | Due to (or | as a conseq | uence of): | | | | | |
| n certificate be executed and use as the burial-transit in/Medical Examiner | Cause (Disease that Initiated ave resulting in deet | or Injury ents th) Last | C | Dua to (or a | as a consequ | uance of): | | | | 1 | |
| th cer tendir truse | | | d | | | | | | | 1 | |
| The law requires that the death rete has been signed by the atter page 2 should be detached for Completed by Physicial | Part II. Other sig | prificant conditions | contributing to death | n but not result | ting in the ur | nderlying cause | given in Part I. | | d tobacco use co | ontribute t | o the cause of death? bably 4 Unknown |
| law requires that as been signed b 2 should be dete | | | | | | | | 24a. Wa | as an autopsy formed? | av cc | era autopsy findings alleble prior to empletion of cause death? |
| octrificate has rector, page 2. | | | | | | | | 10 | Yes 20 No | 1 | □Yas 2□ No |
| certificat rector, p | | farrad to medical | | | | | 26. Place of | Death (Check only | (one) | | |
| Physician: this certific rel director, | examiner? | XI No | Hospital: 1 ☐ Inpa | atient 2 E | R/Outpatien | t 3 DOA | Other: 4 Nursi | ng Home 5 Re | sidence 8 Oth | her (Speci | (y) |
| Attending Physical death. ector: After this by the funerel diffication: To | 27. Manner of D | 5 Pending | | njury Day Year) | 28b. Time of Injury | 28c. In V M 1 | jury at Vork? □ Yes 2 □ No | | e how injury occur | rred | |
| In or Attending Physician: The law requires the after death. Director after this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by | 3 ☐ Suicide 4 ☐ Homicid | 6 ☐ Could not determine | Zee. Place of | Injury - At hometc. (Specify) | ne, farm, str | eet, factory, offic | ee | | (Street and Numi own, State) | ber or Rur | al Route Number, |
| To the Hospital or Attending P within 44 hours after death. To the Funeral Director: After to complately filled in by the funeral Medical Certification: | 29a. Certifier (Check only one) | | Physician: To the bes aminar: On the basis and manner | of examination | | | | | | | |
| To the To the compla | 29b. Signature a | and title of certifiar | A | Alleri | | 29c. Lice | ensa number | | 29d. Data signe | ed (Month, | Day, Year) |
| | Han | nes of o | forsber | ans | 20-1 T |) 3 | 354/ | | 04-0 | 8-9 | 9 |
| | Jame | S L.F. | orsburg | MID | 912 | Wash | instor | Rd. U | Jestoni | u ste | MD |
| State Registrar | 31. Date filed (M | APR 0 | 9 1999 | istrar's Signatu | ire | 5. So | ak | | | | 2113 / |



State of Maryland / Department of Health and Mental Hygier

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| 1. Dec | edent's Name | (First, Middl | fle, Last) | | 7 | | | | | 2. Date of De | | | | 3. Time of Deeth | |
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| an | GLADYS | | | | | KOWA | LEWSKI | | | Month APRII | Day | y 1999 | Year | 9:50PM | |
| er 4a Fac | cility Name (# r | | on, give stre | eet and nu | m <i>ber)</i> | ROWA | DIMOICE | 1 | 4b. City, Town, or Lo | | | . County | | 9:50PM | |
| | ISBURY | CENTE | ER: GI | ENESI | S ELD | ERCARE | | 3 | SALISBURY | MD. | | COMI | | | |
| | el Security Nur | | 6. Sex | | | yrs. last birthe | dev) If Under 1 | Year | If Under 24 Hrs. | 8. Date of Bi (Month, D | | | | lace (Stete or Forei | ign |
| | -01-012 | | 1 M | 2X F | 90 | Yr | S. MORRIS L | Days | Hours Min. | DEC. 1 | 1,19 | 08 | MARYI | | |
| Usual I | Residence of D | Decedent 10b. County | v | | 100 | c. City, Town o | or Location | - | | | | | 4 | 0d. Inside City Limit | |
| | | | | | | | | | | | | | | 1 Yes 2 □ N | |
| 2 | LAND | | COMICO |) | | FRU | JITLAND 10f. Zip Co | nde | | * | 10a Cit | tizan of W | Vhat Coun | ** | |
| 208 | SANDCA | | RI VD | | | | | 218 | 226 | | | | | wy. | |
| 11. Ma | rital Status | DIDE | | Was Dece | edent Ever | in U,S. | | | Ispanic Origin? (Spen, Mexicen, Puerto | ecify Yes or N | | . S . A | | en Indian, | _ |
| - | Never Merried Widowed 4 | - | mied | Armed Fo 1 Tes If Yes, Giv Year or D | orces? 2 X No ve | | If Yes, specify | | en, Mexicen, Puerto Specify: | Rican, etc.) | | Specify: | k, White, | etc. TTE | |
| | 1 | 15. Deceden | nt's Educeti | ion | | 16a. D | ecedent's Usuel C | Occup | ation | | 16b. K | (ind of Bu | siness/inc | | - |
| Elem | (Specify nentary/Second | y only highe dary (0-12) | | om <i>pleted)</i> Coltege (1 | 1-4or 5+) | (6) | five kind of work of the DO NOT use i | retired | during most of worki | ng | | | | | |
| S | 11 | | | 2 | | SI | ECRETARY | | | | | | ING (| CO. | |
| o 17. Fat | her's Name (F | | , Last) | | | | | | 18. Mother's Name | | | | 10) | | |
| e GUY | | С. | | | WHI | | | | ELLA | | WALL | | | | _ |
| | formant's Nam | | | | 0.033 | | | | and Number or Rura | | | | | | |
| | S. KO | | SKI, I | - 11 | | | SANDCAS isposition (Neme | | E BLVD. | FRUITL | | | | own, State | - |
| 10 | Burial 2X | Cremetion | | oval from | | cemetery, | cremetory or othe | er piec | 1 | | 200. LC | Joan of 1 - | ORY OF TO | mil, Gidle | |
| | Donetion 5 | | | | | CAMBRI | DGE CREM | | | /8/99 | | | | MARYLAND | |
| 21. 519 | 01 | Service | A A | 0 | | 00- | 22. Neme end A | 400re | ss or Facility | | 705 | E. 1 | MAIN | ST. | |
| | D. / | elly | 8 | 7.0 | | | | | | | | | | | |
| 23a P | | | , | my | pour, | 11-5/ | | | NERAL HOM | | | ALIS | BURY, | , MD 2180 | 4 |
| s | ert1. Enter the hock, or heart | disease, or feiture. List | r complicat t only one o | ions that cause on e | aused the | death. Do not | | | NERAL HOM | | | ALIS | BURY, | Approximate Intervat Between | 4 |
| | | | r complicat t only one o | - | | | enter the mode of | of dyin | ng, such as cerdiac o | or respiratory | arrest, | | 4 | Approximate Intervat Between Onset and Death | - |
| Immed | ent1. Enter the hock, or heart liete Ceuse (Fi e or condition ng in death) | inat | r complicat t only one o | - | plic | estrons | enter the mode of | of dyin | | or respiratory | arrest, | | 4 | Approximate Intervat Between | - |
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| Immed diseas resulting Sequence Sequence If any, couse. Cause that init resulting Part II. | iete Ceuse (Fi e or condition ing in death) intially list cond leading to imm Enter Underly (Disease or in hated events ig in death) La | ditions, nediate ying jury | b c | Qin. | Due Due | to (or as e con to (or es a con to (or as e con | TRANSPURING OF TRANSPURING OF THE PROPERTY OF | of dyin | ng, such as cerdiac co | 23b. Dtd | arrest, | o uss com | ntributs to 3 Prot | Approximate Interval Between Onset and Death Death Onset and D | C chr |
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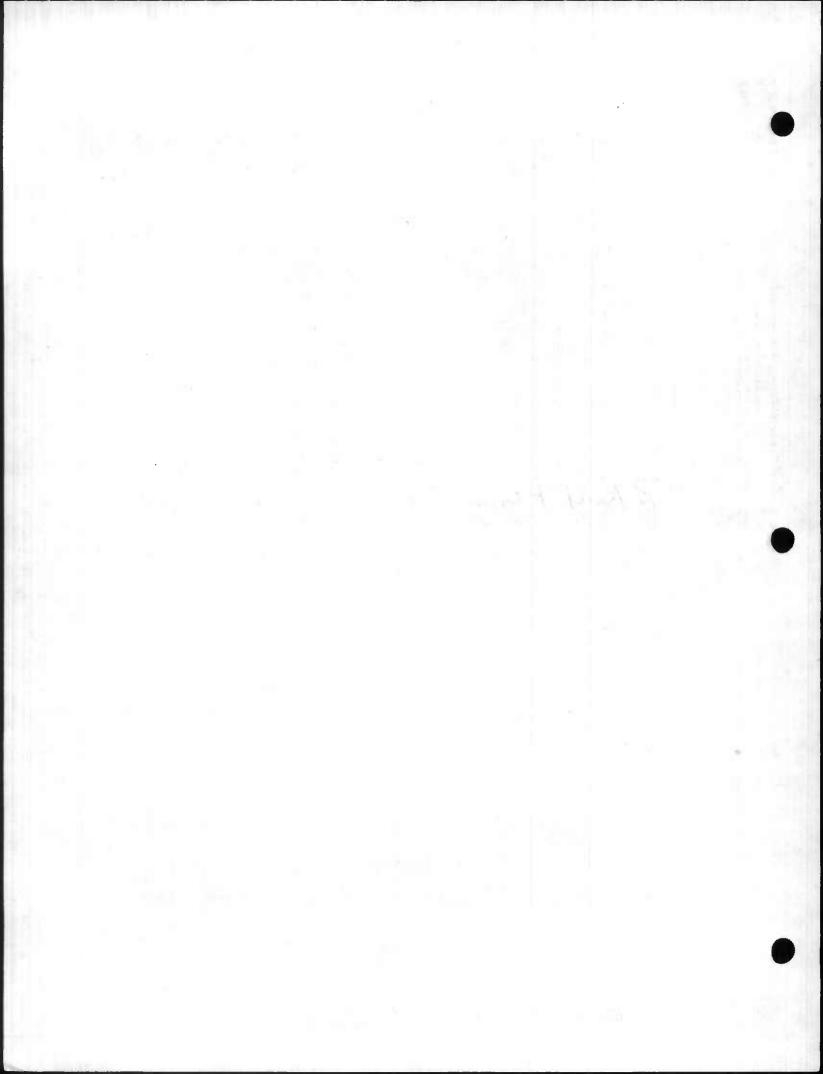
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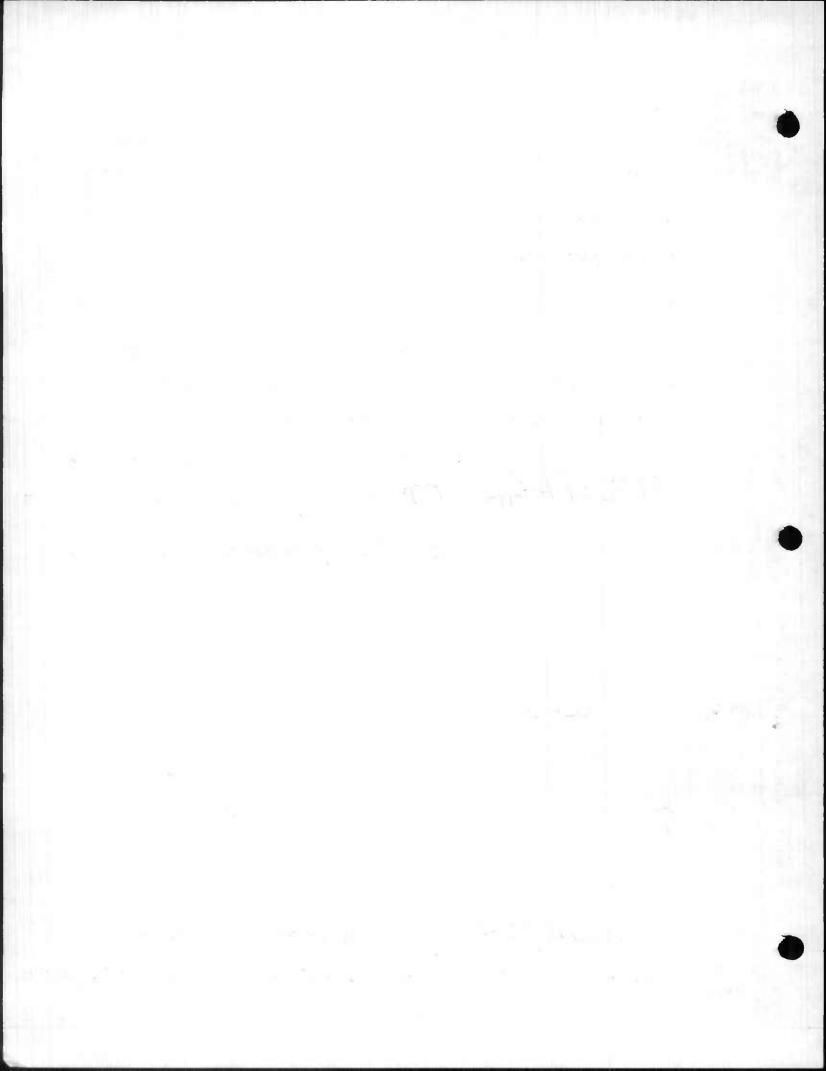
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32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

| PRIVATE DESCRIPTION AND ALTER AND AL | | | | | | | Certific | cate of | Death | | R | eg. No. |) | 21,29 |
|--|---|-------------------|--|--|--|------------------------|--|----------------------------|---|--------------------------|---|--|----------------------|---------------------------------------|
| SARA FINEMAN LONG MARCH 31,1999 6:17 PM Examiner Common Commo | Physici | ion | 1. Decedent's Name (F | irst, Middle, La | st) | | | | | | | | Veer | 3. Tim f |
| ## CODE PENNSYLVANIA AVE. Code C | | | SARA | FREE | MAN | L | ONG | | | | | |) | 6:17 TM |
| School Security Number 10 country 10 c | Examir | ner | 4a. Facility Name (If no | t institution, giv | a street and numb | er) | | | 4b. City, To | wn, or Loc | ation of Death | 4c. County | of Death | |
| 15 - 38 - 025 4 1 | | | | the same of the sa | AVE. | | | | | | Y WICOMICO | | | |
| United Residence of December Use Copy | | | | | | | Mon | | | Min. | Date of Birth (Month, Dey, ΔΤΤC 2 9 | Year) 1908 | 9. Birthple Count | ace (Steta or Ford ry) SVIVANIA |
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| TYes Specify County Memorial Point Remaind 20 Married Process Specify WHITE | how | Director | 10e. State 10 | b. County | | 10c. City, To | own or Location | | | | | | 10 | d. Inside City Lin |
| TYes Specify County Memorial Point Remaind 20 Married Process Specify WHITE | uth with the Me 23e or 28e-f s | | MARYLAND | WICOMIC | 00 | SA | ALISBUR | Y | 124 | | | | | N☐ Yes 2☐ |
| TYes Specify County Memorial Point Remaind 20 Married Process Specify WHITE | | | 10e. Street and Number 10 | | | | | | Of. Zip Code 10g. Citiz | | | | | ry? |
| TYes Specify County Memorial Point Remaind 20 Married Process Specify WHITE | | a | 409 PENNSY | LVANIA | | | | | | | U.S.A | ١. | | |
| Security | | by | 11. Marital Status | | | | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexicen, Puerto I | | | gin? (Spec , Puerto R | | | | |
| Security | urs afte | | | | If Yes, Give | | | | | | Specif | | v. | |
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| 17. Februs Name (First Medide, Later) 18. Mother's Name (First, Medide, Medide, Later) 19. Informant's Name (First, Medide, Later) 19. Informant's Name (First, Medide, Medide, Later) 19. Informant's Name (First, Medide, | withir than | | | | | College (1-4or 5+) | | | | | | | | |
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| D36376 8/1/29 | athin the | ě | | of cortifies | , | | | | | | | | | |
| | 5 × 5 0 | | 255. Signotora and title | | | | | | | 2/ 1/99 | | | | |
| 30. Nama and address of person who completed ceuse of deeth (Item 23e) (Type, Print) RONALD P. TRAVITZ ND SUITE AZOK, 560 RIVERSIDE DR SAKK | | | | | // | | | | | | | 17 | -/ | |
| KONAND T. IRMUITZ ND DUITE HZOM 560 MIVERSIDE DR JAKE | 20 | | _ | - | | | (Type, Print) | | 4- | 47 | ara 1 |) | m = F |) m Su |
| | 7 | | | | | | , MD | DUITE | 1/20 | 7 : | 060 M | IVERS | DE T | K JAKE |
| State Registrar 31. Date filed (Month Day, Year) 1999 32. Registrer's Signature 4 April 1999 | | | 31. Date filed (Month A) | (1 19 | 99 32. Reg | | 4 | lon | 1 | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 3 4 3 0

| | | Certificate of Death | Reg. No. | | | | | | | |
|---|------------------|--|---|---|--|--|--|--|--|--|
| Physicia | an | 1. Decedent's Name (First, Middle, Last) CALVIN SOENCER LOGUE SR. | 2. Dete of Death Month Dey | 3. Time of Death | | | | | | |
| /Medic | al | 4b. City, Town, or Lot | cation of Death 4c. Co | 1999 12:42 A.M. | | | | | | |
| Examin | er | | | arroll | | | | | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) If Under 1 Yaar If Under 24 Hrs. | 9 Date of Birth | 9. Birthplace (State or Foraign Country) | | | | | | |
| Director | 0 | 20265604 10M 20F 68 Yrs. Months Days Hours Min. | NOV 21, 193 | O COUNTY) MD | | | | | | |
| /land | | 10a. Stete 10b. County 10c. City, Town or Location | | 10d. Insida City Limits | | | | | | |
| Man | tor | MD CARRILL WESTMINSTER | | 1 ☐ Yas 2 ☐ No | | | | | | |
| with the Maryland a or 28a-f show be notified at | Funeral Director | 10e. Street and Numbar 10f. Zip Coda | 10g. Citizer | n of What Country? | | | | | | |
| death w | ral | 923 WASHINGTON ROAD 21157 | U: | SH | | | | | | |
| er de | nue | 11. Marital Status 12. Was Decedant Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto F | Rican, etc.) | . Raca - Amarican Indian, Black, White, etc. | | | | | | |
| Si " " " | by F | 1 Never Married 2 Married 1 Yes 2 No It Yes, Give 1 Yes 2 No Specify: | Si | pecity: WHITE | | | | | | |
| 15-0020 72 hours at natural', or | per | | 16b. Kind | of Business/Industry | | | | | | |
| TT C 1 50 | Completed | 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) | - Contract of the Contract of | 44 4 | | | | | | |
| and 212. be filed within that Hygiene. d other than | Con | 12 PURCHASING HEE | | TE OF MD. | | | | | | |
| be filed that Hyging other | To Be | | (First, Middle, Maiden Su | | | | | | | |
| should be not marked imatic events | 7 | 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rure | E SPEN | CER | | | | | | |
| Mac do 2 mar trau | | 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19b. Malling Address (Street and Number or Rure 19c. Malling Address (Street and Num | 21157 | OWII, State, 219 Code) | | | | | | |
| re, r Heal r Heal tem 2 | | 20a. Melhod of Disposition 20b. Piece of Disposition ARM | / Pate / 20c. Loca | ition - City or Town, State | | | | | | |
| 5 80 = 9 | | Buriel 2 Cremetion 3 Removal from Stata 4 Donalion 5 Other (Specify) | /14/99 WE: | SIMINSTEV, MD | | | | | | |
| Baltim pemit. Pe Departmen Important: any Injury pnce. | | | 145 FUNEAU | AL HOME CHAPEL | | | | | | |
| Depariment of the police. | | WESTMINSTER, MA | ROAD | 1157 | | | | | | |
| | | 23a. Part Enter the disease, or complications that cabsed the death. Do not enter the mode of dying, such as cardlac of shock, or heart failure. List only one cause on each line. | or respiratory errest, | Approximate Interval Between | | | | | | |
| Physician | | | | Onset and Death | | | | | | |
| /Medical Examiner | | Immediate Ceuse (Final disease or condition resulting Indeath) | m | 2hu | | | | | | |
| | - | resulting In death) | | | | | | | | |
| uted ansit | Examiner | Sequentially list conditions. Due to (or as a gonsequence of): | | sogne | | | | | | |
| 60, be executed sician and buriel-trensit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ((000 | 7011 | | | | | | |
| 68760 ficete be e physician is the buri | edical | Cause (Disease or injury that Initiated avents rasulting in death) Last Due to (or es a consequenca of): | | | | | | | | |
| 200 | 2 | L a | | | | | | | | |
| Records, P.O. Box elaw requires that the death cel has been signed by the attendit ge 2 should be detached for use | Physician/ | | | i . | | | | | | |
| P.O. | hysi | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown | | | | | | | |
| F 60 | | | 75(165 25 | NO SEPTOBERY YESOTKHOWN | | | | | | |
| ords requires seen sign hould be | Pa P | | 24a. Was an autopsy performed? | available prior to | | | | | | |
| aw re | Completed by | | | completion of cause of death? | | | | | | |
| I Rec | | A STATE OF THE PARTY OF THE PAR | 1 □ Yes 2 🔀 | No 1 Yes 2 No | | | | | | |
| of Vital Records, Physicien: The law requires t this certificate has been signs ral director, page 2 should be. | Be | 25. Was case referred to medical examiner? | (Check only one) | | | | | | | |
| of Vita Physicien: this certific | 2 | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor 27, Manner of Death 28a, Date of Injury 28b, Time of 28c, Injury at | ma 5 Residence 6 [28d. Describe how injury of | | | | | | | |
| Division of the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | tion | 1 Natural 5 Pending (Month, Dey Year) Injury Work? | 200. Describe now injury t | occurred | | | | | | |
| | Certification: | 3 Suicide 6 Could not be | | Number or Rural Route Number, | | | | | | |
| | erti | determined determined determined determined building, etc. (Specify) | | | | | | | | |
| | | 29a. Certifier (Check only 2 | | | | | | | | |
| | edical | one) and mannar stated. | | | | | | | | |
| | Σ | 29b. Signature and title of certifier 29c. License number | 29d. Dete : | signed (Month, Dey, Year) | | | | | | |
| | | Johnmiddle U2 443 | 4 | -12-47 | | | | | | |
| | ĺ | 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) | TE TON, M.D. | 21157 | | | | | | |
| Stat | 10 | 31. Date filed (Month, Dey, Year) 32. Registrer's Signature | week, | | | | | | | |
| Registra | | APR 1 2 1999 Serve B. Sparks | | | | | | | | |

BARRETT STATE OF STREET and an interest the first To the Holesand Contract Con 270 MARIE THE THE PALES Marie L. Dienien. CALVIN COURS DE SAM TESTATURES MARTINES EL SE And the state of t Day of the second second second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LOSTZ CA 1930 ANGUST 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SHOCK TRAUMA CENTER UNWERNTY OF MARYLAND 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | MAR 24, 1916 5. Social Security Number 6. Sex 9. Birtholace (State or Foreign 10 M 2□ F MARYLAND 216-05-7330 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 3924 TURKEYFOOT ROAD 21158 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No 194 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1945 WHITE 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) BALTIMORE CITY POLICE OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARGARET NICHOLSON JULIUS FREDERICK LOETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, WESTMINSTER, MD. 21158 DOROTHY RUTH SPICER / DAUGHTER 3924 TURKEYFOOT ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition APR 15 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State KEYSVILLE UNION CEMETERY KEYMAR, MARYLAND 1999 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SKILES FUNERAL HOME TANEYTOWN, MD 21787 136 EAST BALTIMORE STREET 1 um 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIORGAN FAILURE 2 WEEK Due to (or as a consequence of): NECROTIZING SOFT 2 X33W + INFECTION 3MEZIT Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hothknown RENAS INSM FFICIENCY 24a. Was an autopsy CORDNAPU ARTERY

Physician /Medical Examiner

physician and s the burial-transit

signed by 1

Completed

Be

edicai

Box 68760

P.O.

Records.

Division of Vital

death.

or Attend after death Director:

To the Within 2 To the

e Funeral DI

2

Physician

/Medical

Examiner

Funeral

Director

than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic avent.

Baitimore, Maryland 21215-0020

Director

Funeral

Be

2

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

25. Was case referred to medical

1 Yes 2 No

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. CHIRONIC

32A3210

2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 TYPE 2 DING

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined

28b. Time of 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and fittle of certifler a Mr

29d. Date signed (Month, Day, Year)

Baltimore up 21201

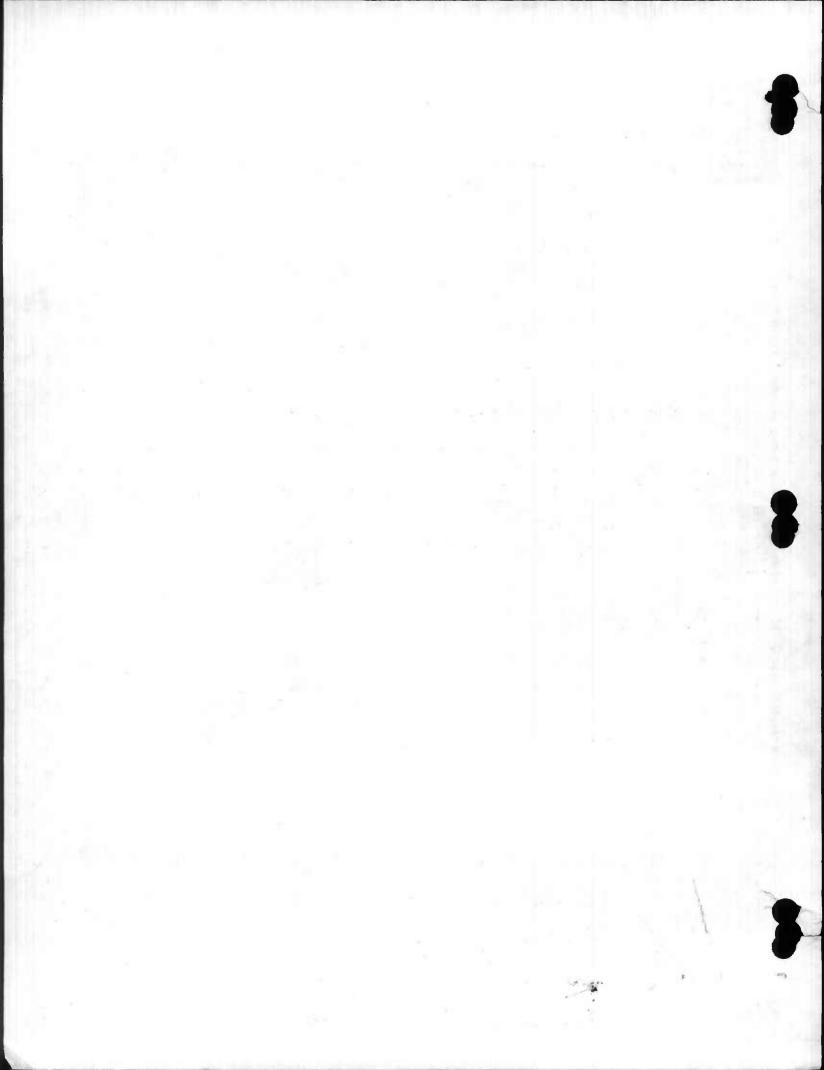
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Wilos II MD RAdous Cowley Shok Traum Center Charles 31. Date filed (Month, Day, Year)

State Registrar

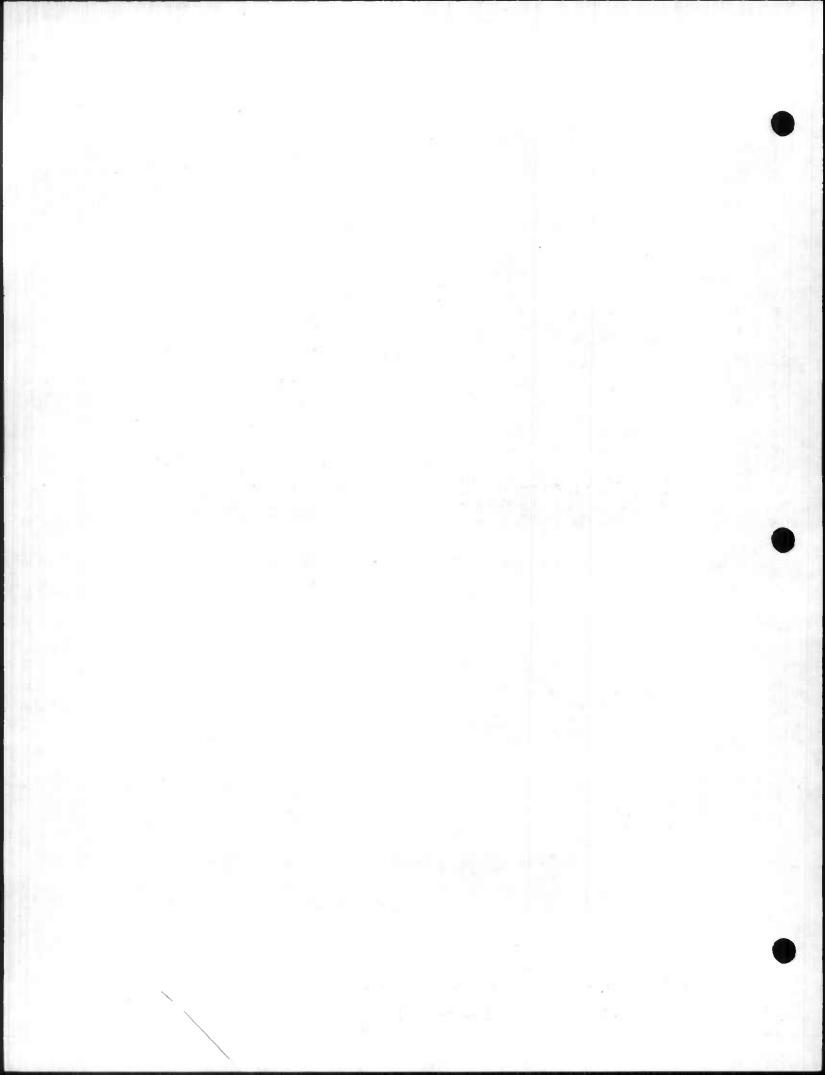
APR 1 3 1999

32. Registrar's Signature Geneva



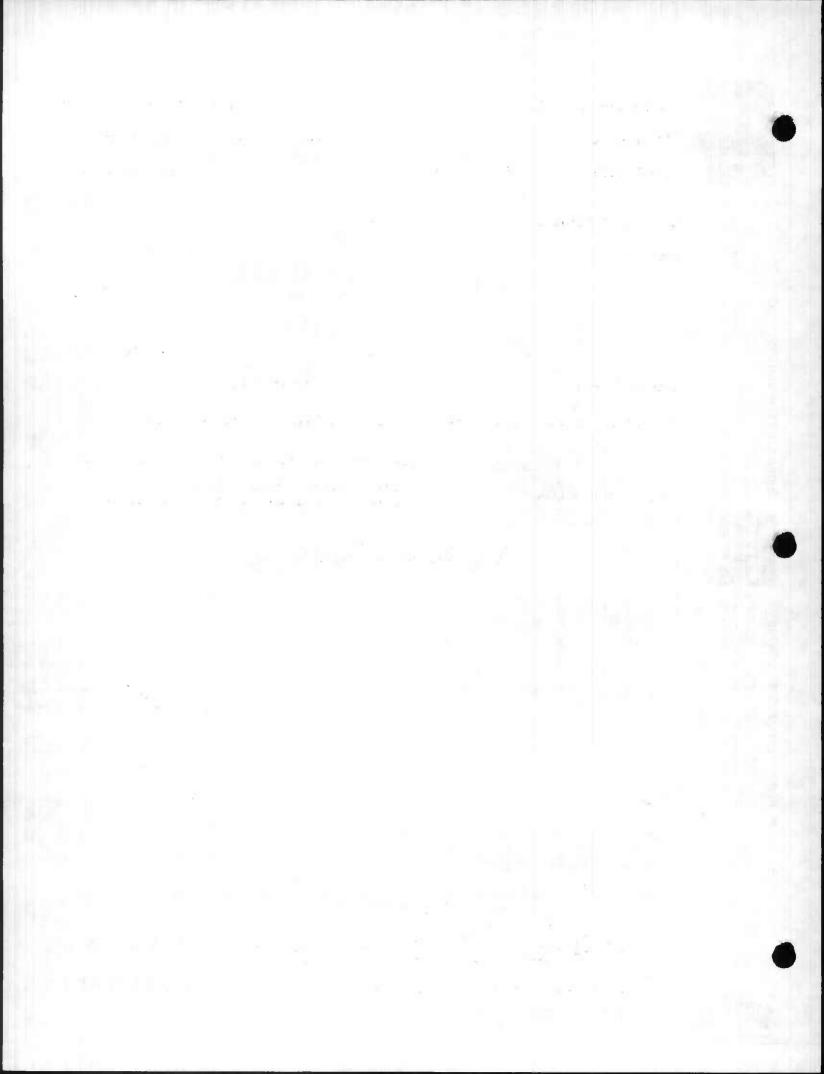
State of Maryland / Department of Health and Mental Hygiene

| | | | Otato of Maryla | | rtificate of | | | eg. No. | 13432 | | | |
|--|--|--|--|---------------------------------|--|------------------------------|---|------------------------------------|--|--|--|--|
| | Dhuaisian | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deal Month | | 3. Time of Death | | | |
| /Media | Physician /Modical | Oliver | Brice | | Ma. | Lcom | | 3, 1999 | 2:45 PM | | | |
| | Examiner | 4a Facility Name (If not institution, give | | | | 4b. City, Town, or L | | 4c. County of | | | | |
| | LAGITITIO | Salisbury Center: | , MD | Wicomico | | | | | | | | |
| Funeral | Funeral | 5. Social Security Number 6. S | ax 7. Age (In yr. | s. last birthday) | If Under 1 Year | | 8. Date of Birth (Month, Day) | | 9. Birthplace (State or Foreign Country) | | | |
| | Director | 217–10–3710 | ⊠м 2□F 83 | | Months Days | Hours Min. | November | 3,1915 | Kentucky | | | |
| with the Maryland s or 28a-f show be notified at | å u | 10a. State 10b. County | 10c. C | City, Town or Lo | ocation | | | | 10d. Inside City Limits | | | |
| | led to | Maryland Wicomi | LCO | Salisb | ury | | | | 1 ☐ Yes 2X No | | | |
| | e or zha-f be notifie Directo | 10e. Street and Number 2814 Merritt Mil | 11 pd | | 101. Zip Code 218 | 24 | 1 | 0g. Citizen of Wh | iat Country? | | | |
| 6 | nust b | | | 110 140 | | | 7. 14 | | I. Race - American Indian, | | | |
| 21215-0020 d within 72 hours after de plene. r than "natural", or thems the Medical Examiner. | D En | 11. Meritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 ½ Yes 2 □ No ÀX If Yes, Give Year or Dates: WW | 7 If Yes, specify Cuben, Mexics | | | Rican, etc.) | | White | | | |
| 5-0 | ygiere. Ne than 'natur It, the Medical. Completed | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | 16a. Dece | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | 16b. Kind of Business/Industry | | | | |
| 2 | to Maria | Elamentery/Secondary (0-12) | College (1-4or 5+) | life. | ille. Do Not use retired) Owner/Operator | | | | | | | |
| 2 2 | the state | 6 | _ | Own | | | Amoco Se | | ervice Station | | | |
| D all | d other | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | | | ne (First, Middle, Maiden Surname) | | | | |
| ig p | Senta Se e Se e O | Vernon Edward Ma | alcom | | | Ida M | ae Hill | | | | | |
| Maryland | Dan L | 19a. Informant's Name/Ralationship (7 | 'ype, Print) | 19b. Maiti | ng Address (Stree | and Number or Ru | ral Route Number | , City or Town, S | tata, Zip Code) | | | |
| M S | 6 th | Ida Lee Malcom/V | Vife | 281 | 4 Merrit | t Mill Rd | Salis | bury. MD | 21804 | | | |
| 9 . | F 14 | 20a. Method of Disposition | | Place of Dispo | osition (Name of | Ţ | - | | ity or Town, Stete | | | |
| Baltimore | 5 = 5 | 1 XBurial 2 Cremation 3 | | | matory or other pla | 1 | 4/7/00 | G-11 h | 100 | | | |
| 二二 | and Control | 4 Donation 5 Other (Specify | | | emorial Pa | | 4/7/99 | Salisbu | ry, MD | | | |
| B & | Depa Impo any i any i | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | | | | | | | | |
| | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediata Causa (Final | | | | | | | | | | |
| P | nysician | | | | | | | | | | | |
| | Medical | | | | | | | | | | | |
| E: | xaminer | disease or condition rasulting in death) | a. Could w. | 2004 | Teach | 1 | | | 910 | | | |
| | — — = | Due to (or as sycongequence of): | | | | | | | | | | |
| Pe | n and ial-transit Examiner | | often | otron |) | 1470-2 | 4 | | gens. | | | |
| , wascu | al-tra | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | uentially list conditions, Que to (or as a consequence of): y, leading to immediate | | | | | | | | | |
| 9 | ysician ne buri | Cause (Disease or injury | C | | | | | | | | | |
| . Box 68760, death certificate be executed | physician and s the bunal-transit edical Examir | resulting in death) Last | Due to | (or as a conseq | quence of): | | | | | | | |
| X Suring | Ph # | | | | | | | | | | | |
| Box ath cert | attending I for use as | | 0. | | | | | | | | | |
| - ag | ed fo | Part II. Other algorificant conditions of | art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I | | | | | | ribute to the cause of death? | | | |
| P.O. | signed by the attending to be detached for use a detached for use a detached for use a detached for use and by Physician/M | 0.00 | | 1 Yes 2 No 3 Probably 4 Uni | | | | | | | | |
| S, F | be de py P | 2 white | | | | | 24a. Was an autopsy 24b. Ware autopsy findings | | | | | |
| Records, P.O | d big | | | | | | | | | | | |
| 00 0 | 11 S | | | perfor | performed? available prior to completion of cau | | | | | | | |
| Rec | m De 2 | | | | | | | | of death? | | | |
| = = | Co | | | | | | 1 Y | es 2 Carno | 1 ☐ Yes 2 ☐ No | | | |
| of Vital Physician: Th | certificate harector, page | 25. Was case referred to medical examiner? | A F No. I | | | | th (Check only or | (9) | | | | |
| Of Physic | this cal din | TES ZE NO | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | th. : After the funera | 27. Manger of Deeth 1 Netural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Wo | ny at nk?] Yes 2 □ No | 28d. Describe how injury occurred | | d | | | |
| | rs after death. al Director: After t ed in by the funer: Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | | | | | 28l. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | Prai C | | | | | | | | | | | |
| | in 24 hou he Fune pletely fil edical | 29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s and manner stated. | | | | | | | | | | |
| | To the composite of the | 29b. Signature and titla of certifier 29c. License number | | | | | | 9d. Data signed | (Month, Day, Year) | | | |
| | | 1 ml | 9 | 4/5/99 | | | | | | | | |
| | Α. | 30 Name and Advanced assessment | oraniated course of death (to | om 22a\ (Tim- | Point) | 11/ | | 1// | 1 | | | |
| MJ | IVA | 30. Nama and address of person who o | 10 - 117 | ern ∠38) (Type, | 11 (1 | | 7.0 | Ind | MD DIGOIL | | | |
| 17 | 12.410(10.000) | an Date filed (Month, Day, Year) | 32. Registrer's Sign | 1104 | realt | nway | 50° 30 | lisbury | MD 21804 | | | |
| 110 | State Registrar | APR 0.6 19 | | ~ 4 | lan | | | - | | | | |
| | Tro grant ar | MIN UDIO | | | 111/100 | | | | | | | |



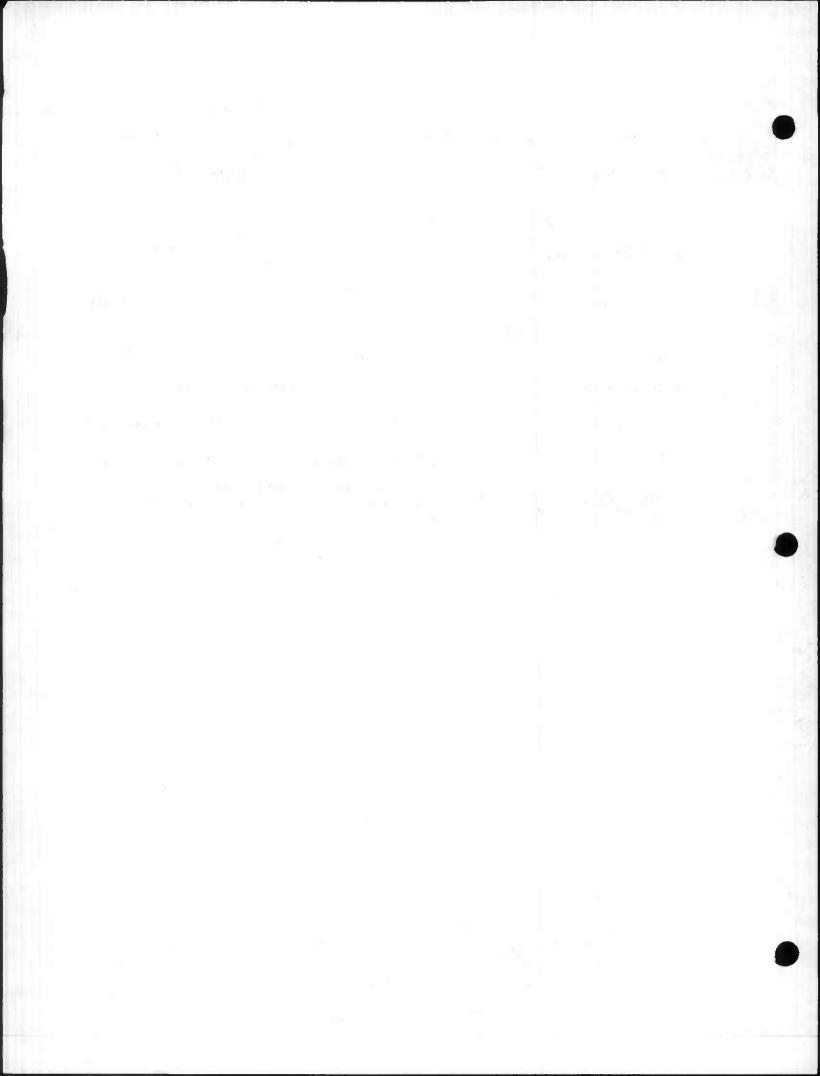
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death April Day 1999 **Physician** 7, 5:30 AM Linda Lee McDonald /Medical 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Reisterstown 200 Erin Way 8. Date of Birth (Month, Day, Yaar) Mar. 2, 1947 9. Birthplace (Stata or Foreign Country) Mary Land If Undar 24 Hrs. If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🖫 F Months Days 52 216-48-2210 Director Usual Rasidance of Dacedani deeth with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 No Directo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21136 United States 200 Erin Way Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Item any Injury or other traumatic event, the Wedgett Enameronce. Black, Whita, atc. 1 Nevar Married 2X Married White Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highest grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Store Clerk Dry Cleaners llth 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Janet Hall Arthur G. Beall 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 200 Erin Way Reisterstown, MD 21136 Charles E. McDonald (Husband) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Lake View Memorial Park 4/9/99 Sykesville, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Nama and Address of Facility 21. Signatura of Funeral Dervice Licensaa Burrier-Queen Funeral Home 1212 West Old Liberty Rd. Winfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequanca of): Examiner attending physician end I for use es the bunal-transit death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Box 68760 Physician/Medicai Dua to (or as a consequanca of) 23b. Did tobacco usa contribute to the cause of death? signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 8 24b. Wara autopsy findings availabla prior to complation of cause of daath? 24a. Was an autopsy performed? page 2 should Completed peen certificate has 2 No 1 Yas 1 ☐ Yes 2 ☐ No 25. Was case rafarrad to medical axamidar?
1 ✓ Yas 2 ☐ No Hospital or Attending Physician: Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Dhasidance 10 8 Othar (Specify) After this 28a. Data of Injury (Month, Day Year) unerel 27. Manney of Daath 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Panding Invastigation s efter death. 1 ∏Yas 2 □ No 2 Accidant the 6 Could not be datarminad 3 □ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 Homicida 24 hours 29a. Cartifiar 1 Cartifying Phyaician: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. nar: On the basis of examination (Check only one) and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) within 2 To the 29d. Data signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of sers 28489 ompletad causa of daath (Itam 23a) (Type, Print) 30. Nama and addrass of person wh Heights Westminsler MD 21157 Washington 224 45 32. Ragistrar's Signatura 31. Data filad (Month, Day, Yaar) State Jener APR 0 8 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Departy R. Moore Continued Processing C | | | | | | | , | Ce | rtificate c | of Death | | Reg. No. | | |
|--|----------|--|--|--|--------------------------------|---|-----------------|------------------|---------------------|---|-------------------------------------|---------------------------------|--------------------------------|-----------------------------------|
| Jerry II. Moore Jerry III. M | | Division 1 | | 1. Decedent's Nama | (First, Middle, La | ist) | | | | | | | | 3. Tima of Death |
| ## Sample of the statistics of | | | | Jerry H | . Moore | | | | | | | | | 0546 |
| PENNINSULA RECIONAL MEDICAL CENTER SALISBURY Section Search years and section of section of the control of th | | | | | | a street end nu | m <i>ber)</i> | | | 4b. City, Town, | | | | |
| Part Departmen | | | | | | | | | | | | | | |
| Top State Top Color Top | | Director | | 218-30-15 | 64 | | | | | | 8. Data of B (Month, D 2-14-1 | irth ev. <i>Year)</i> 935 | 9. Birthplac Country | ca (Stete or Foreign v) Md . |
| Charles Moore Charle | | Manda Manda | | 10a. State | 10b. County | | 10c. C | ity, Town or L | ocation | | | | 100 | d. inside City Limits |
| Charles Moore Charle | | 28a-f sh ottfed | ector | | | СО | | Delmar | | | | | | Y Yes 2 No |
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| Charles Moore Charle | 0020 | ral', or items | by | 1 Never Marrie | _ | Armed Fo | rces? 2 No | U,S. 13. | | | (Specify Yas or Nerto Rican, atc.) | | ck, White, at | c. |
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| Physician Medical Examiner Physician Medical Examiner Physician Medic | Bal | Depart Import any In | | 21. Signature of Fundamental | eral Service Licar | nsae | 10 | 1 | Short Fu | neral Hor | | | | |
| Physician Middled Examiner Consequence of Conseq | | _ | | 23a Part 1 Enter the | disease or com | Inlications that o | aused the rise | utty Dri not en | 3 E. Gr | ove St. I | Delmar, I | e. 1994 | | Annrovimete |
| Immediate Cause (Final Part Imme | | the column | | shock, or heart | failure. List only | one cause on e | ach line. | 7 | tor the mode or t | synig, soon as oard | nac of respiretory | ariost, | lr. | nterval Between |
| Second of the control of the contr | | | | Immediate Cause (F | inal | 1 | 1 | | | | | | 9 | 0 |
| State Sequentially list conditions, if any, leading to immediate cause. Einer Underlying cause given in Pert I. Due to (or as a consequence of): a pure to (| | | | diseasa or condition | | a (10) | de | | mas | 1 | | | m | w. |
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| Cause (Disease or Injury Internal Inter | | al-tra | xai | Sequentially list cond if any, leading to imm | ditions, nediate | | Due to | or as a conse | quenpe of): | | | | 10 | |
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| 1 Yes 2 No 1 Yes N | o s | the | ysic | Part II. Other signific | ant conditiona | contributing to de | eath but not re | sulting in the u | inderlying cause | given in Pert I. | 23b. Dlo | tobacco uae co | ontribute to ti | he cause of death? |
| 1 Yes 2 No 1 Yes N | G. | and by and detac | | neps | enfort | 4 | | | | | 10 | Yes 2□No | 3 Proba | bly 4 🗆 Unknow |
| 1 Yes 2 No 1 Yes N | ecord | as been sig 2 should b | | sus; | loth | 7 | | | | | | | availe | able prior to pletion of ceuse |
| The state The | œ 3 | nte h | Ю | | / | | | | | | 1 | Yes 2 No | 101 | Yes 2□ No |
| The state The | ita | rtifice stor, I | 0 | | d to medical | | | | | 26. Place of E | Deeth (Check only | one) | 1 | |
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| 30. Neme and address of person who completed cause of death (item 23a) (Type, Print) William H. Robins M.D. 1104 Healthway Dr. Salis muy, Md. State 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature | Josephan | E4 hours Funeral taly filled | | (Check only 2 | Certifying Ph Madical Exam | niner: On the ba | sis of examin | owledge, deat | h occurred at the | time, date end ple y opinion, death of | ice, end due to the | cause(s) and m | anner as stat end due to th | led. he ceuse(s) |
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| William H. Robins M.D. 1104 Healthway Dr. Salishury, Md. | F | \$ P 8 | - | 255. Signature and th | 7 Cartiner | 5/1/ | /_ | | 290. LICI | - 07. | 19 | 7/_ | // A | iy, 1 au/) |
| William H. Robins M.D. 1104 Healthway Dr. Salishury, Md. | | | | 1/ | / // | 110 | | | a | 2717 | | 1/51/ | 40 | |
| State State Registrar 31. Dete filled (Month, Dey, Yeer) APR 0 5 1999 32. Registrar's Signature | | 10 | | 1 . 11 | - 11 | A 1 | | om 23a) (Type, | | ealthwa | u Br. | Salish | ula. | Md. |
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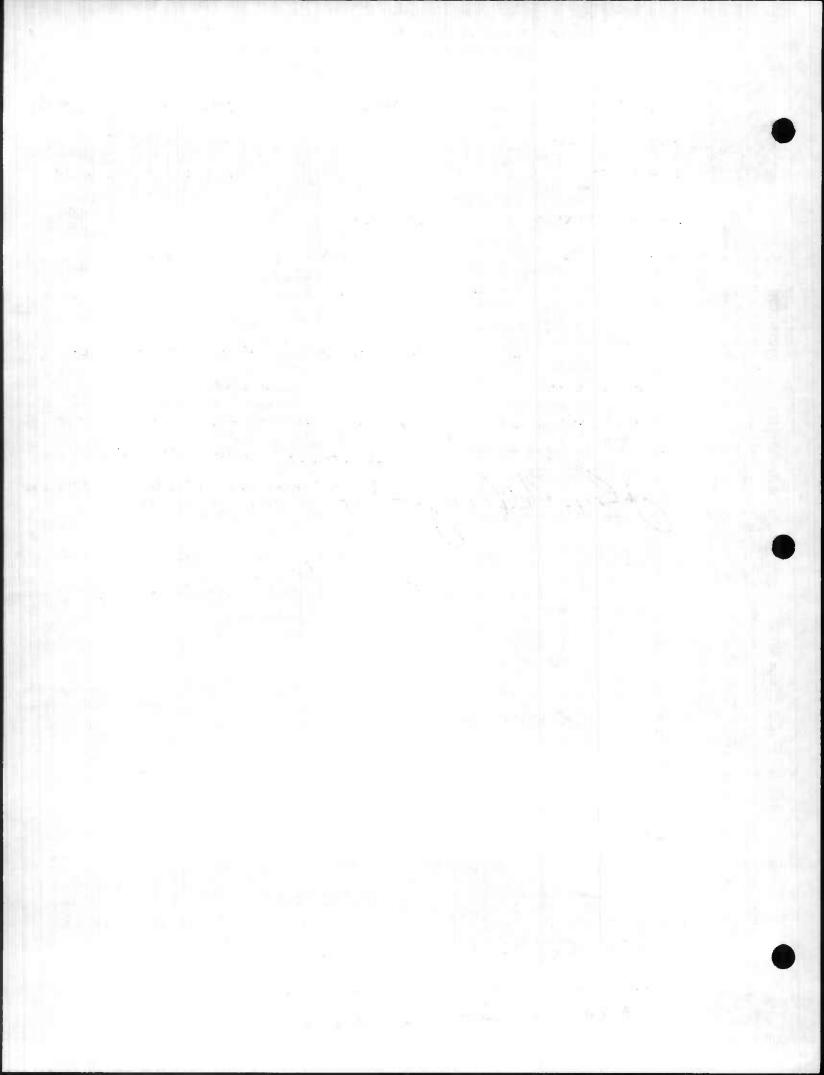
State of Maryland / Department of Health and Mental Hygiene 9 9 1 3 4 3 5

| Certificate of Death | Reg. No. | |
|--|--|--|
| 6 | Month Day | Year 3. Time of Death |
| | | 1999 J. OFF |
| | | Cry 011 |
| 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 | | 9. Birthplace (State or Fore |
| 577 05 5425 10 M 20 F 89 Yrs. Months Days Hours Min. | KB 1 1910 | Country) VA |
| Usuel Residence of Décedent 10a. Slata 10b. County 10c. City, Town or Location | | 10d. Inside City Lim |
| MA CARROLL WESTMINSTER | | 1 Yes 2 7 |
| 10e. Street and Number 10f. Zip Code | 10g. Citizen of | What Country? |
| | \mathcal{U} . | SA |
| Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri | ify Yes or No- ican, etc.) 14. Rad Bla | ce - American Indian, ck, White, etc. |
| 3 DWidowed 4 □ Divorced Yeer or Detes: | Specif | WHITE |
| 15. Decedent's Education (Specify only highest and e completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working | 16b. Kind of B | usiness/industry |
| Elementary/Secondary (U-12) College (1-40/5+) | | TING GOODS |
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| Charles Chever Annie | E LEGG | |
| | | , State, Zip Code) |
| DICAD IVICAULSUN / SON | Weslmins | (cr. 11.1.2115 |
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| disease of Colidition | C | ITWO B |
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| Sequentially list conditions. Due to (or as a consequence of): | | |
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| that initieted events resulting in death) Last Dua to (or es e consequence of): | | t |
| d | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I | 23b. Did tobacco usa co | ontribute to the cause of de |
| | 1 □ Yes 20 (No | 3 Probably 4 Unk |
| | , | 0.00 111-1-1-1-1 |
| | 24a. Was an autopsy performed? | 24b. Wera autopsy findir available prior to completion of cause |
| | +FIVes aNas | of death? |
| 25. Was case referred to medical 26. Place of Death (| 1 | 10 168 230 160 |
| axaminer? Hospital: / Other | | ner (Specify) |
| 1 Netural 5 ☐ Panding (Month, Day Year) Injury Work? | 3d. Describe how injury occur | rred |
| 3 Suicide 6 Could not be | M Location (Street and Num | her or Rural Route Number |
| 4 Homicida datermined building, etc. (Specify) | City or Town, State) | Der Grittan Floote Number, |
| | | |
| 29e. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, an | nd due to the cause(s) and m | anner as stated. |
| (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred and manner steted. | d at the time, date and place, | and due to the cause(s) |
| (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred | d at the time, date and place, | and due to the cause(s) ed (Month, Day, Year) |
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| (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred and manner steted. 29b. Signature and fille of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | d at the time, date and place, | and due to the cause(s) od (Month, Day, Year) |
| | 1. Decedent's Name (First, Middle, Last) APVER Number APVER Number Apver | 1. Decedent's Name (First, Middle, Last) APVER APVE |

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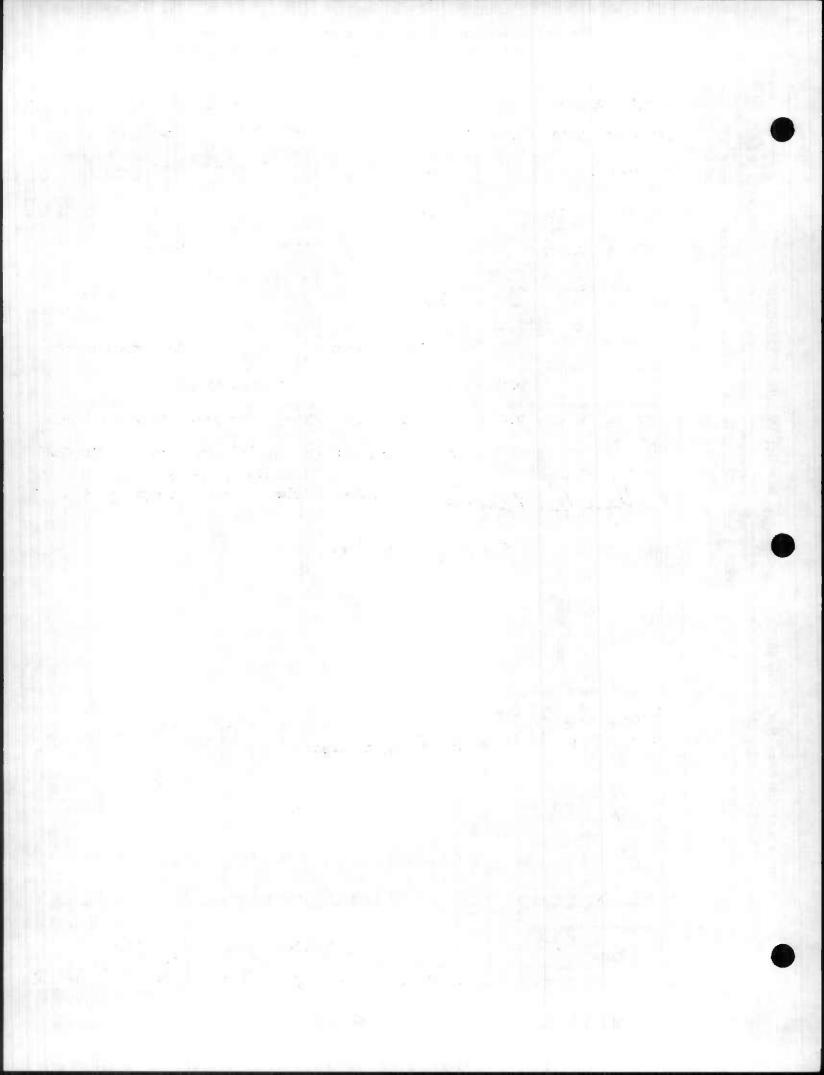
State of Maryland / Department of Health and Mental Hygiene

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| Physician | | ecedent's Name (First, Midd WILLIAM | ile, Last) | н. | | ואמ | RSON | C | | 2. Date of Month | Death Day | 999 | Year | 3. Time of Death |
| /Medical | 40 5 | acility Name (If not institution | on nive stre | | -) | PA | ROUN | | lb. City, Town, or | Apri. | | County o | of Death | 8:15 P.M. |
| Examiner | | 1324 Main Str | | er and number, | , | | | | Pitts | | | icon | | |
| uneral irector | 21 | ocial Security Number | 6. Sex 1 ₩ M | 2□ F 7. A | ge (In yrs. 87 | last birthday) Yrs. | If Under Months | r 1 Year Days | if Under 24 Hr. Hours Mir | | | | | ace (State or Forei ry) ryland |
| ž == | - | State 10b. County | у | | 10c. Cit | y, Town or Loc | ation | - | | | | | 10 | d. Inside City Limi |
| to to | Ma | aryland Wic | omico | | | Pittsv | ille | | | | | | | 1 ☑ Yes 2 ☐ N |
| r items 23e or 28e-f showning must be notified at Funeral Director | 10e. | Street and Number 34324 Main St | | | | | 10f. Zip | Code 218 | 50 | | | zen of W | hat Count | iry? |
| r items | | Meritel Status Never Married 2 Mar Widowed 4 Divorced | rried | Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates: | ? | 1 | es Deced Yes, spec | | ispanic Orlgin? (nn, Mexicen, Pue Specify: | Specify Yes or rto Rican, etc.) | | | - America c, White, e | |
| if them 27 is marked other than "naturel", or other traumatic event, the Medical Exart of the To Be Completed by | Ek | 15. Deceder (Specify only higher ementary/Secondary (0-12) | est grade co | on ompleted) College (1-4or | 5+) | | ind of wo O NOT u | ork done o ise retired | ation during most of wi Highw uction e | ay | | | High | |
| event, Be C | 17. F | ather's Name (First, Middle, | , Last) | | | | | | 18. Mother's Na | | _ | | | |
| aumentic event, the M | T | Thomas A. Par | sons | | | | | | Annie | L. Whit | e | | | |
| a m | | Informant's Name/Relation | ship (Type, | Print) | | 19b. Meiling | Address | s (Street | and Number or F | Rural Route Nur | nber, City or | Town, S | State, Zip | Code) |
| ther tr | - | Villiam L. Pa | rsons | /Son | | | | | cean Cit | | 7 | - | _ | |
| important: if item 27 any injury or other u once. | | Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5) | 3 □Remo | oval from State | 9 | Place of Dispos cemetery, crem Pittsvi | | | | Date 4/9/99 | | | City or Too | |
| vsician ledical aminer | resu | Part Enter the disease of the Cause (Final ase or condition liting in deeth) | or complication only one c | ions that cause cause on each l | con | 3 5 | 01 Si | now de of dyln | Hill Rd. ig, such as cerdi | ac or respirator | sbury, | | | SOCIATION 4 Approximete Interval Between Onset end Deeth |
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| certificate has been signed by the attending physician and rector, page 2 should be deteched for usa as the burial-transit augmenter or sector, page 2 should be deteched for usa as the burial-transit augmenter and page 2 should be deteched for usa as the burial-transit augmenter. | Sequiform cause Cause their resu | wediate Cause (Final ase or condition ase or condition alting in deeth) uentially list conditions, y, leading to immediate se. Enter Underlying se (Disease or Injury initieted events liting in death) Last II. Other significant conditions are conditionally in the condition of | a b c d Hosping | Gora | Due to (c | Do not ente | O1 Sir the mod | ceuse giv | en In Part I. 26. Place of Doer: 4 Nursing | 23b. D 1 24e. W pt 11 eath (Check on Home 5 17 | Id tobacco Yes 2 as en autopromed? Yes 2 yone) | Use con No | tribute to 3 Prob 24b. We ave cord of c | Approximate Interval Between Onset and Deeth Deeth Dee |
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| his certificate hes been signed by the attending physician and all director, page 2 should be deteched for use as the burial-transit arising the completed by Physician/Medical Examiner | Imm dise result for the result for t | wediate Cause (Final ase or condition ase or condition of the condition of the conditions, and the conditions, and the conditions, and the conditions of the | a. dons contributed in the service of the service | pital: 1 Inpati 28a. Date of Inj. (Month, Di. | Due to (of Due to (of my knoof examina | Do not ente | on Sir the moc | ceuse giv | Hill Rd. Ing. such as cerding. Ing. such as | 23b. D 23b. D 1 24e. W pt 28d. Descril 28f. Locatio City or | id tobacco Yes 2 Yes 3 Yes 4 Yes | Use connection of the control of the | tribute to 3 Prob 24b. We ave corror of control of the control of | Approximate Interval Between Onset and Death The cause of death wably 4 Unknown or autopsy finding allable prior to impletion of cause death? I Poute Number, eted. |
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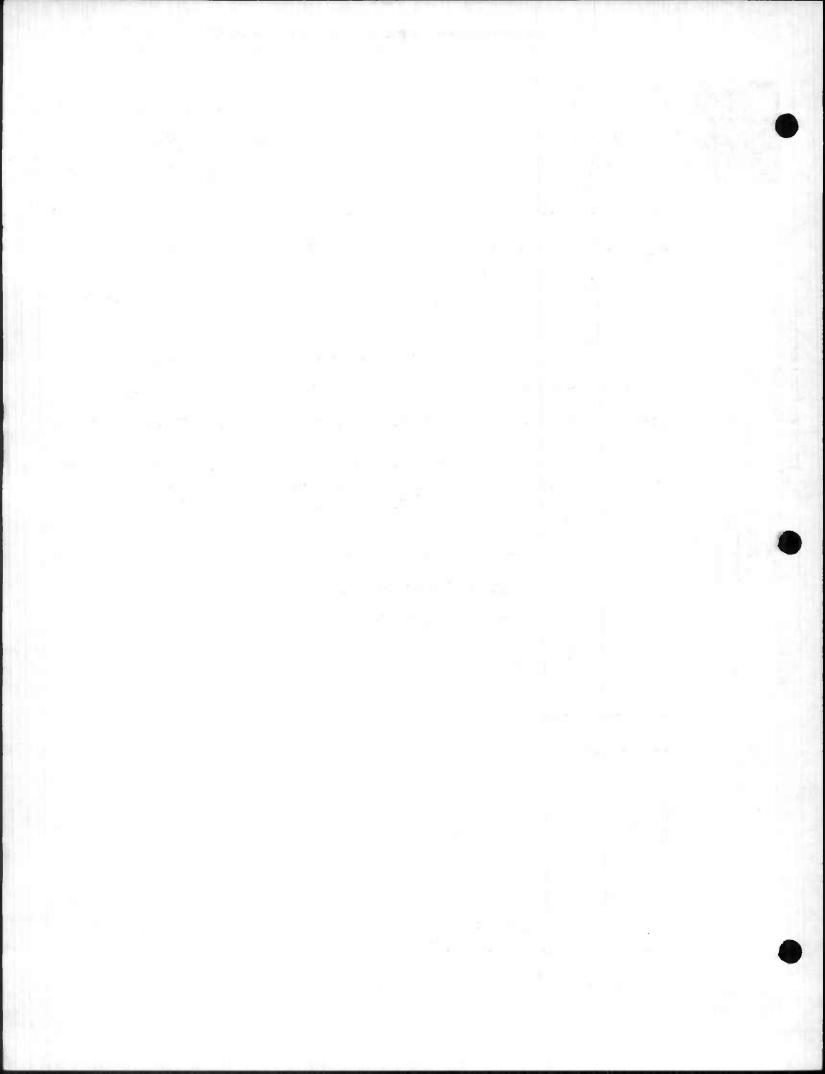


Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 13 13 7

| | | | Certificate of | of Death | , | Reg. No. | | 0.77.0 |
|--|--|---|--|--|--|-----------------------------|------------------------------|---|
| Physician | 1. Decedent's Neme (First, Middle, La | | | | 2. Data of Dea | Dev | Yeer | 3. Tima of Deeth |
| · /Medical | OATES ATTION | | | T | APRIL | 10, 1 | 999 | 5:20 A.M. |
| Examiner | 4e Facility Neme (If not institution, gir FREDERICK MEMOR: | | | 4b. City, Town, or L FREDERIC | | 4c. County FREDE | | |
| Funeral Director | 212-09-7080 | Sax 7. Age (In yrs. | 82 Yrs. If Under 1 Y | eer If Under 24 Hrs. eys Hours Min. | 8. Data of Birt Month, Day JUNE 8, | V. YOUT) | 9. Birthpl Count MARYL | lece (State or Foreign try) LAND |
| r 28a-f ahow | Usual Residence of Decedent 10a. Stete 10b. County Maryland Carroll | | neytown | | | 7 | 10 | 0d. Inside City Limits 1 ☐ Yes 2 No |
| Iter deeth with the Maryland r items 23a or 28a-f show stret must be notified at | 10e. Street end Number 4380 Angell R | oad | 10f. Zip Co | 21787 | | 10g. Citizen of V United | | |
| 020 urs after alr, or the | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Evar in U Armed Forcas? 1 X Yes 2 No If Yes, Give Yeer or Detas: 194 | 43- 1□ Yes 2X | of Hispanic Origin? (Sp Cuban, Maxican, Puerto No Specify: | pecify Yes or No- Rican, etc.) | 14. Rac Biad Specify | e - America ck, White, e | |
| within within then then then then then then then the | 15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) | | 16a. Decedent's Usuel O (Give kind of work d life. DO NOT use re Crane Opera: | | king | 16b. Kind of B | | |
| Maryland 2 d 2 should be filled the and Mental Hygi the and Mental Hygi the and Mental Hygi the and th | 17. Fathar's Nama (First, Middla, Las | Matthew Pink | as | 18. Mothar's Nem | ne (First, Middle, Ces Havl | | 10) | |
| EZNE | 19e. Informant's Neme/Ralationship Mary M. Pinkas | / wife | 19b. Meiling Address (St 4380 Angel | 1 Road | ral Route Number Taneytow | m, Mary | land | 21787 |
| Page Page nent o | 20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetton 5 Other (Special Contents) | Removel from Stete S+ | | holic Cem | Apr. 14 1999 | | wn, M | wn, Stete Maryland |
| Baltimo permit. Page Department of Important: If any Injury or pnca. | 21. Signeture of Funeral Servica Lice | nsee | | ddress of Fecility Signature Baltimore | | neral Ho Taneyt | | MD 21787 |
| Physician /Medical Examiner | 23a. Pert1. Entar the disease, or con shock, or heart feilure. List only Immediate Ceuse (Finel disaese or condition resulting in deeth) | . Severe | th. Do not enter the mode of | | or respiretory er | rest, | | Approximate Interval Between Onset and Deeth |
| I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the ettending physician and page 2 should be detached for use as the buriel-transit. | Cause (Disease or injury that initiated avents resulting in death) Lest | c | or es e consequence of): or as a consequence of): | | | | | 311 |
| The law requires that the death certine has been signed by the ettending page 2 should be detached for use a Completed by Physician M. | Pert II. Other significant conditions | contributing to death but not res | sulting in the underlying caus | e given in Pert I. | 23b. Did 1 | V | | the causa of death? |
| Records, he law requires the hes been signed age 2 should be completed by | Interstition | 1 tipuzie | from sili | 21700 | 24a. Wes perfo | en eutopsy rmed? | 900 | ere autopsy findings eileble prior to mpletion of causa deeth? |
| of Vital Re Physician: The la this certificate he rel director, page | 25. Wes case referred to medical exeminer? | Hospitei: | | 26. Place of Dee | | one) | | Yes 2 No |
| Vision or Attending Ph or death. actor: After thi by the funeral | | 28e. Dete of injury (Month, Day Year) | PR/Outpatient 3 □ DOA 28b. Time of Injury M 28c. M 28c. M 28c. M 28c. M 28c. M 28c. M 3 M 28c. M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M | Injury et Work? 1 Yes 2 No | | now injury occur | red | il Routa Number, |
| To the Hospital or within 24 hours aft to the Funeral Direct Completely filled in Medical Cert | 29e. Certifier (Check only one) 1 Certifying Pi | nysician: To the best of my knominer: On the basis of exemine end menner stated. | | | | | | |
| To the comp | | 4 | 29c. Li | 2 1944 | | 29d. Dete signe | od (Month, | Day, Year) |
| State | 30. Name and address of person who are so that the source of person who are so that the source of th | completed cause of deeth (Iter | 300 m 91 | st, | Freder | ich | mx | 21701 |
| Registrar | APR 1 3 19 | 99 Beneva | B. Apo | the | 1 | | | |



| _ | | | | | Maryland / Dep | partment of artificate of | | | ene 1. No. 9 (| 13 | 4.38 |
|------------|--|------------------|--|--|---|--|--|--|------------------------------|--|--|
| | Physic /Medi | | Decedant's Nama (First, Middla, L CLAUDE WILLI. | | MAN, SR. | | | 2. Data of Death Month April 1 | Day 3 | Yaar | 12:10 m |
| P) | Exami | | 4a. Facility Nama (If not Institution, grace CIVISTA MEDICAL (| | or) | | 4b. City, Town, or I | | 4c. County | | |
| | Funeral Director | | 221-18-0821 | Sax 11XM 2□ F | Aga (In yrs. last birthda 68 Yrs. | Months Days | r If Undar 24 Hrs. Hours Min. Fe | 8. Data of Birth (Month, Day,) bruary | (ear) 5,193 | 9. Birthplaca (Country) New | State or Foreign Jersey |
| | death with the Maryland ms 23a or 28a-1 show mant be notified at | tor | Usual Rasidance of Dacedant 10a. Stata 10b. County Char | les | 10c. City, Town or Port | Location Tobacco |) | | | | sida City Limits |
| | th with the 23a or 28 | Funeral Director | 10e. Street and Number 7784 Ann Harb | or Drive | | 10f. Zip Coda 206 | 577 | 10g | J. Citizan of V JSA | What Country? | |
| 020 | 72 hours after dea natural', or items zical Examiner m | by | 11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedal Armed Forca 1 2 Yas 2 [If Yes, Giva Yaar or Datas | nt Ever In U,S. s? No 1952 :-1956 | . Was Decedant of if Yas, specify Cut 1 ☐ Yas 🏋 No | Hispanic Origin? (Span, Maxican, Puart Specify: | pecify Yas or No- o Rican, atc.) | Blac | e - Amarican Ind ck, Whita, atc. : White | lian, |
| 21215-0020 | c • a | Completed | 15. Dacedant's E (Specify only highast gi Elamantary/Secondary (0-12) | Education rada completed) Collaga (1-4o | r 5+) (Given life. | | i during most of wor ed) | king | | usinass/Industry | |
| Maryland 2 | uld be filed withi fental Hygiene. rked other than tic avent, tre M | To Be C | 17. Fathar's Nama (First, Middle, Las William George | | | ler-Mak | 18. Mothar's Nan | na (First, Middia, Ma | idan Suman | , | r |
| Many | d 2 shorth and N is me trauma | | 19a. Informant's Name/Ralationship Nettie M. Peter | (Type, Print) | 19b. Ma | | t and Number or Ru | ral Routa Number, (| City or Town, | Stata, Zip Code | |
| Baltimore, | permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic avent, once. | | 20a. Method of Disposition 1 Burial 2 Cramation 3 | ☐Ramoval from Stat | 20b. Place of Discematary, cr | position (Nama of ematory or othar pla | ace) | | c. Location - | City or Town, S | itata |
| Baltin | permit. Pa Departme Important any Injury | | 4 □ Donation 5 □ Othar (Spec 21. Signatura of Funaral Sarvice Lice | ensaa | MODITHA | 22. Nama and Addr RFHART | ass of Facility | 4/19/99 | UOME | D A | ı,MD |
| | 20540 | | 23a. Part1. Enter ha disaasa, or cor shock, or ha in failura. List only | choly L | P P P P P P P P P P P P P P P P P P P | .O. BOX | 567 LA | PLATA, M | D 206 | 46 Ann | roximata |
| | Physician /Medical Examiner | | shock, or the lift failura. List only tmmediata Causa (Final disaasa or condition rasulting in daath) | | ^{lina.} entricular | | | | - | | val Batween at and Death |
| | n # | ner | , | Ische | Dua to (or as a cons mic Cardion | | | | | | |
| | and and il-trans | Examiner | Sequantially list conditions, if any, leading to immediate causa. Enter Underlying | D | Dua to (or as a cons | equance of): | | | | | |
| 68760, | icate be executed physician and s the burial-transit | edical E | that initiated avents | c | ary Artery Dua to (or as a conse | | | | | | |
| Вох 68 | death centifica e attending ph id for use es th | | rasulting In death) Last | d | | | | | | | |
| O. E | 0 0 0 | Physician/M | Part II. Other significant conditiona | contributing to death | but not resulting in the | undariying causa g | ivan In Part I. | 23b. Did tobe | acco use co | ntribute to the o | causa of death? |
| S, P. | 8 5 8 | by Ph | Multisystem Org | an Failur | e | | | 1 🗆 Yes | 2□ No | 3 Probably | 4 🗆 Unknown |
| Records, | aw requi | Completed | _Cardiac Cachexi | a | | | | 24a. Was an a parforme | autopsy d? | avallabia | atopsy findings a prior to ion of causa ? |
| tal | E sign | Be Co | 25. Was casa rafarrad to medical | | | | 26 Place of Dee | 1 ☐ Yas | 2 No | 1 ☐ Yas | 2□ No |
| of Vital | 5 0 0 | ToB | axaminar? 1 □ Yas 2 💢 No | Hospital: 1 1 Inpa | tiant 2 ER/Outpati | ent 3 DOA | har | oma 5 Rasidan | ce 6 □Oth | ar (Specify) | |
| on o | ding h. After June | | 27. Mannar of Death 1 K Natural 5 □ Panding 2 □ Accidant invastigation | 28a. Data of In (Month, L | jury (ay Year) 28b. Tlma Injury | Wo | ıryat ork?]Yas 2 □ No | 28d. Dascribe how | injury occur | red | |
| Division | To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the luneral | Certification: | 3 Suicida 6 Could not datarminad | be 28a. Place of I | njury - At homa, farm, s atc. (Spacify) | street, factory, office | | 28f. Location (Stre City or Town, | at and Numb Stata) | er or Rural Rou | la Number, |
| | 24 hours 27 hours Funeral etely filled | edical | 29a. Cartifiar (Check only one) 1 ☐ Cartifying Pi | hysician: To the bes minar: On the basis and manner: | t of my knowledga, das of axamination and/or l | nth occurred at tha t nvastigation, in my | lma, data and place opinion, daath occu | , and dua to tha cau rrad at tha tima, data | sa(s) and ma a and place, | nnar as stated. and dua to tha c | ausa(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | a00 | 01 | 29c. Lican | sa number | 290 | . Data signe | d (Month, Day, 1 | rear) |
| | | | 30. Name and address of person who | completed cause of | death (Item 23h) (Time | D 4 | 4718 | 4 | 1/13/9 | 7 | |
| | | | Rendolph A. | DE Carlo, N | 10) 701 E | . Charles | St. Capla | fr, ms 2 | 0646 | | |
| | Sta Registr | | 31. Date filed (Month/Day, Year) APR 1 4 | 1999 32. Řegi | trar's Signatura | 9. Som | 1.1 | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician PETERSON** VIRGINIA CAROL APRIL 8, 1999 5:10 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10230 BRIARWOOD PLACE WALDORF CHARLES Hours Min. 8. Data of Birth (Month, Dey, Year) Months Days 5. Social Security Number 7. Aga (in yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Days 1 M 2 F 578-56-4979 WEST Director 56 MARCH 6, 1943 VIRGINIA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 1 No Director MARYLAND CHARLES WALDORF 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 10230 BRIARWOOD PLACE 20601 Funeral death 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. of 2 should be filed within 72 hours effer of the and Mental Hygiene.
It is marked other than "natural", or fiel traumatic avant, to wed. 1 Yas 2 No 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: WHITE Aq 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) . Pages 1 and 2 should be filt ment of Haalth and Mental Hant: If item 27 is marked oth jury or other traumatic avany Be WILMER BAYS MYRTLE RILING 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) PAMELA I. DE LOZIER/DAUGHTER 2665 HUSK PLACE, APT. 103, WALDORF, MARYLAND 20602 20b. Place of Disposition (Name of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Removel from Stata permit. Page Department of important: It any injury o poce. ST. JOSEPH'S CHURCH CEMETERY 4/13/99 POMFRET, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Fullaral Service Ucanada THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX JPK DOHN P. KNISLEY M01164 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onset and Death **Physician** Metakens to bran /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner Ulym nn Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 TYes 2 No. 3 Probably 4 Unknown been signed t should be det Records, h 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa refarred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 3 DOA 28a. Data of Injury (Month. Day Year) 27. Menper of Death 28h Time of 28d. Describe how injury occurred

or Attending Physician: funeral director. After this 24 hours after death. filled in

Certification: To

Neture 2 Accident 3 Suicida

4 Homicide 29a. Certifier

29b. Signature and title of certifier

(Check only one)

5 Pending invastigation 6 Could not be

28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28c. Injury at Work? 1 | Yas 2 | No

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d Date signed (Month, Day, Year)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Daniel M. Howell, 11345 Pembrooke Sq. #104, Waldorf, MD 20603-4804

State Registrar

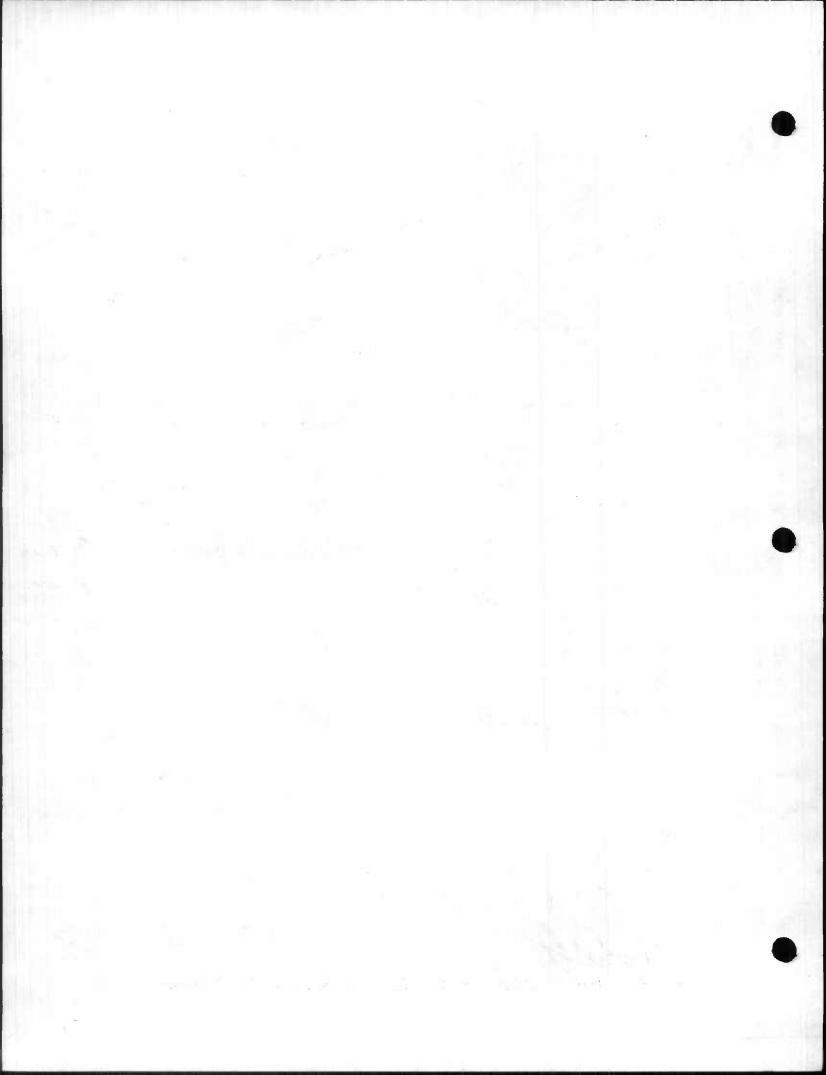
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31. Data filed (Month, Dey, Year) APR 13 32. Registrar's Signatura

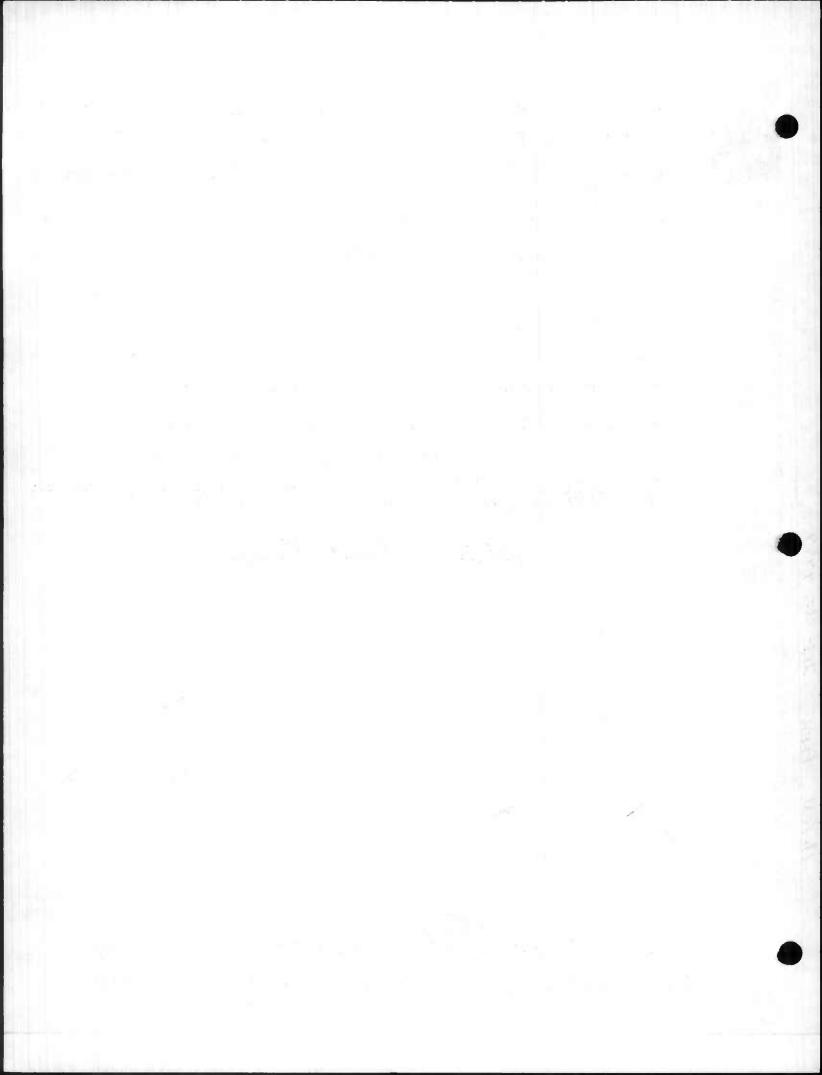
Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

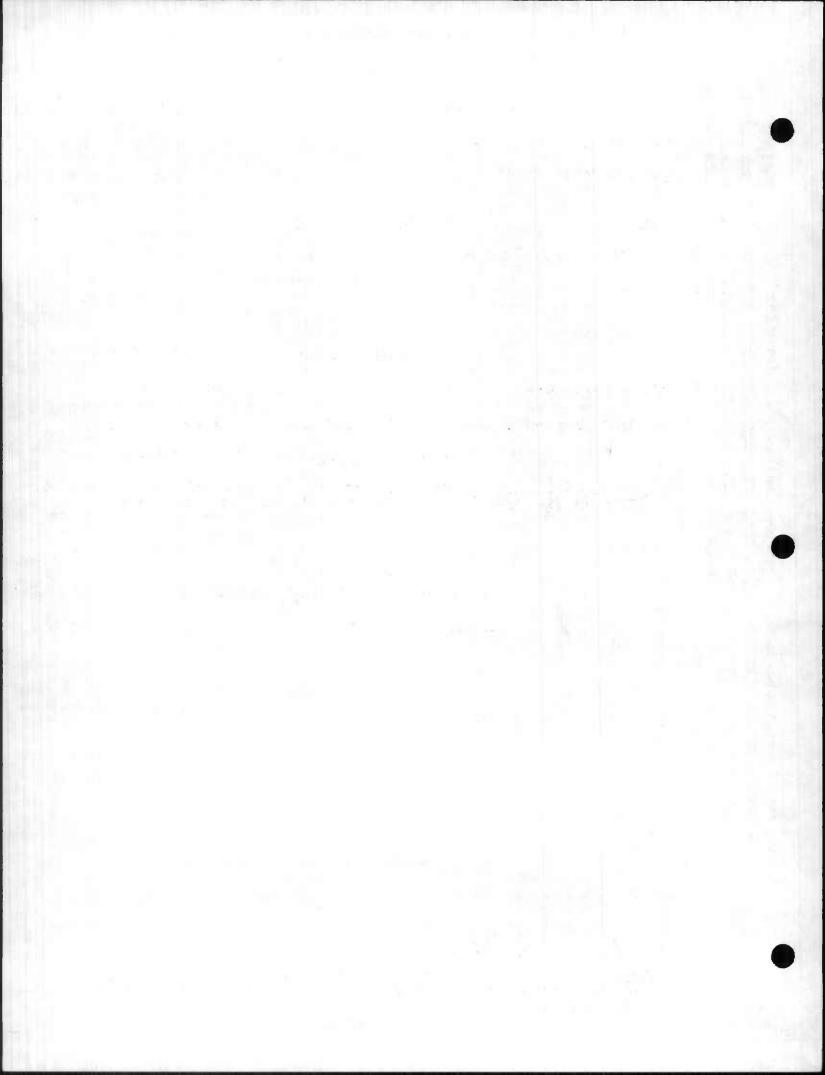
| | | | | State of Maryle | | rtificate of | | | Reg. No. | 13440 |
|---------------------|---|---------------------|---|--|-----------------------------|--|--|---|--|--|
| | Dhysial | | 1. Decedant's Name (First, Middla, Last) | | | 0 / | <i>i</i> . | 2. Data of Dea | | 3. Tima of Death |
| - | Physici /Medio | | Helen | Juse | | Peek | | | 3 1999 | |
| | Examir | | 4a. Fecility Neme (If not institution, give s PENINSULA REGIONAL | | ENTER | | 4b. City, Town, or SALISI | | County or | Death OMICO |
| | Funeral Director | | 215-26-4999 | M 2⊠F 7. Aga (In y | rrs. last birthday) Yrs. | If Under 1 Year Months Days | | | y, Year) 20, 1931 P | Birthplaca (Stata or Foreign Country) Ennsylvania |
| | pue M. | | Usuel Residance of Decedant 10a. Stata 10b. County | 10c. | City, Town or Lo | ocation | | | | 10d. Insida City Limits |
| | the Marylen 28a-f show nour ed | lor | Maryland Worceste | | Eden | | | | | 1 ☐ Yes 22 No |
| | r 28a-f | rec | 10e. Street and Number | | | 10f. Zip Coda | | | 10g. Citizan of Wha | at Country? |
| | death with the Marylend ms 23a or 28a-f show mast be notified at | ai D | 7412 Meadow Bridge | e Rd. | | 21822 | | | USA | |
| 020 | or the | by Funeral Director | 11. Marital Status 1 Naver Married | Was Dacedent Ever in Armed Forcas? □ Yas 2☑ No If Yas, Giva Yaar or Dates: | | Was Decedant of I If Yas, specify Cub 1 ☐ Yas 22 No | Hispanic Ongin? (Spen, Mexican, Puer Specify: | Specify Yas or No- to Rican, etc.) | 14. Race - Black, Specify: | American Indien, Whita, etc. White |
| Maryland 21215-0020 | within ene. | Completed | 15. Decedant's Educ (Specify only highast grade Elementary/Secondary (0-12) | cation complated) College (1-4or 5+) | (Give | dant's Usual Occu kind of work dona DO NOT usa retire ISEWITE | pation during most of wo ad) | orking | 16b. Kind of Busin | |
| P | i Hygorther | BeC | 17. Fathar's Nama (First, Middle, Last) | | | | 18. Mothar's Na | ma (First, Middle, | Maiden Sumame) | |
| /lar | Vente Mente rked rtic ev | To B | Vester Franklin O | sborne | | | Locki | e Mae Ro | ten | |
| lan | and h | | 19a. Informant's Name/Ralationship (Typ | oe, Print) | 19b. Mailir | ng Addrass (Stree | t and Number or R | ural Routa Numbe | er, City or Town, Ste | ata, Zip Code) |
| | and lealth m 27 | | John Henry Peek/H | | | | Bridge | | n, MD 218 | |
| Baltimore, | permit. Peges 1 and 2 should be filed Department of Health and Mentel Hygis important: If item 27 is marked other any injury or other traumatic event, any injury or other traumatic event, and once. | | 20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Ri 4 □ Donetion 5 □ Othar (Spacify) | amovel from State | | natory or other pla | | Data 4/7/99 | 20c. Location - Cit Salisbur | |
| Bal | permit. Pe Departmen Important: any injury | | 21. Signatura of Funaral Service Licensa | m0105 | H | | Funeral : | | fessional ury, MD 2 | Association |
| | | | 23a. Part1. Entar tha disaase, or complice shock, or heart failure. List only on | etions that caused tha de | | | | | | Approximata Intarval Batween |
| | Physician /Medical Examiner | | Immediate Causa (Final disaasa or condition rasulting in daath) a | Makestan | tie. | | a Can | en | | Onsat and Death |
| | | Jer | | Dua to | o (or as a consec | quence of): | | | | |
| 0, | icate be executed physician and s the burial-transit | Examiner | Sequantially list conditions, If any, leading to immediate causa. Entar Undarlying Causa (Disease or injury that initialed events | Dua to | o (or as e conseq | juance of): | | | | |
| (68760, | rificate be executing physician and set the burial-trans | Medicai | resulting in daath) Last | Dua to | o (or as a conseq | uence of): | | | | |
| Box | death cert e attendin ed for use | lan | d | | | | | | | |
| P.O. | het the dea | Physician/M | Pert II. Other significant conditions conf | ributing to death but not i | rasulting In tha u | ndarlying causa gi | ven in Part I. | 23b. Did 1 | ~ | bute to the cause of death? Probably 4 Unknown |
| Records, | w requires thet the death certifi been signed by the attending should be detached for use ex | Completed by | | | | | | 24a. Was perfo | an autopsy 2 | 24b. Were autopsy findings available prior to complation of cause of death? |
| Re | The law rate has b | THO I | | | | | | 300 | No. | 1 □ Yes No |
| Vital | ician: The certificate rector, pag | BeC | 25. Was casa rafarrad to medical | | | | 26. Placa of De | ath (Check only o | ne) | |
| Į V | S S D | To B | examinar? | ospital: Nopatiant 2 | P □ ER/Outpetler | nt 3 DOA Ot | har | | dence 6 Other | (Specify) |
| Division of | nding Phath. r: After the funeral | | 27 Mannar of Death 1 Natural 5 Panding 2 Accidant Investigation | 28a. Deta of Injury (Month, Day Year | 28b. Tima of Injury | Wo | ryat ork?]Yas 2 □ No | 28d. Describe h | now Injury occurred | |
| Divis | To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral | Certification: | 3 ☐ Suicida 6 ☐ Could not be 4 ☐ HomIcida determIned | 28a. Place of Injury - A building, atc. (Spe | t homa, farm, str acity) | aat, factory, office | | 281. Location (S City or Tox | | or Rural Routa Number, |
| | Hospi 24 hour Funer tely fill | edicai | 29a. Cartifiar (Check only one) Certifying Physical Medical Examin | cian: To the best of my ler: On the basis of axam | mowledge, death | occurred at tha ti | ma, data and piac opinion, daath occ | e, and due to tha urred at tha tima, | cause(s) and mann data and placa, sno | er as stated. d dua to the causa(s) |
| | of the of the comple | Med | 29b. Signature and title of contiller | and mannar statad. |) | 29c. Licen | se number | | 29d. Date signed (f | Month, Day, Year) |
| | 6 ≒ ≰ ⊣ | | (1)/K | 1111 | W | 1 2 | 6275 | 2 | 4-3 | -99 |
| | | - | 3Q. Nama and address of person who cor | npleted cause of death (I | tem 23a) (Type. | Print) | 0 - 1 0 | -, | 1) | // |
| | 10 | | David (acoll MD | 145 E. | Carroll | 15% | Sel | 54,1 | 40: | 21801 |
| | Sta Registr | - | APR 0 6 199 | 9 32. Ragistrar's Sig | gnatura | Span | KN | 0' | | |

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| miner | 4a F | | f not institution, giv | | | | | 4b. City, Town, or | | 4c. County | of Death |
| | | niv of | f Md. I | | | s. last birthday | If Under 1 Ya | | B. B. Dafe of Bir | th Cul | 704 FG |
| ral tor | 2 | 14-34- ai Residence of | - 7393 | 1 M 2 V F | 7. Age (m y/s | OW Yrs. | Months Day | | | | 9. Birthplacy State of Country) Delaware |
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| Sire | 10e. | Street and Num | | | | | 10f. Zip Cod | | | 10g. Citizen of V | What Country? |
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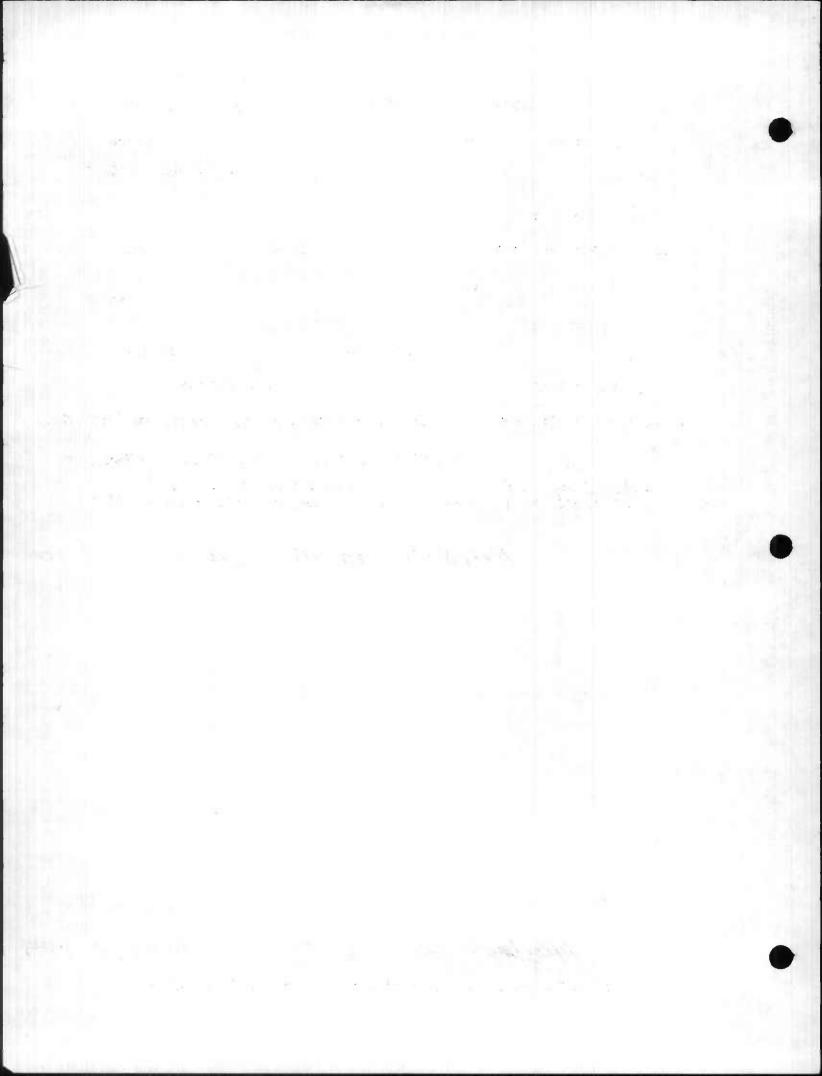
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death **Physician** RENNER DONNA YVONNE 1999 April 1:30 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Charles 3398 Williamsburg Drive Waldorf If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Aug. 5,1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 201F Months Deys Hours Yrs. Florida Director 61 578-48-6243 Usuel Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at The Maryla Maryland Charles Waldorf 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3398 Williamsburg Drive 20601 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 Never Merried 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene important; if items 27 is marked.

By any injury or other in. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Own home Homemaker 12 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be BERTHA ANAHEIM DONALD JENKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Jacob A. Renner/Husband 3398 Williamsburg Drive, Waldorf, Maryland 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 XBurial 2 Cremation 3 Removel from State Edge Hill Cemetery 4/12/1999Charles Town, WV 4 Donation 5 Other (Specify) 22 Name and Address of Facility
The Huntt Funeral Home, Inc. of Fulheral Si KNISLEY P P.O. Box 156, Waldorf, Maryland 20604 mew M01164 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): resulting in deeth) Lest signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 | Yes 2 | No p 24b. Were autopsy findings eveilable prior to completion of cause of death? should should 24a. Was an autopsy Completed has e 2 his certificate has il director, page 2 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Deeth
12 Naturel
2 Accident 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Yes 2 No n 24 hours after death.

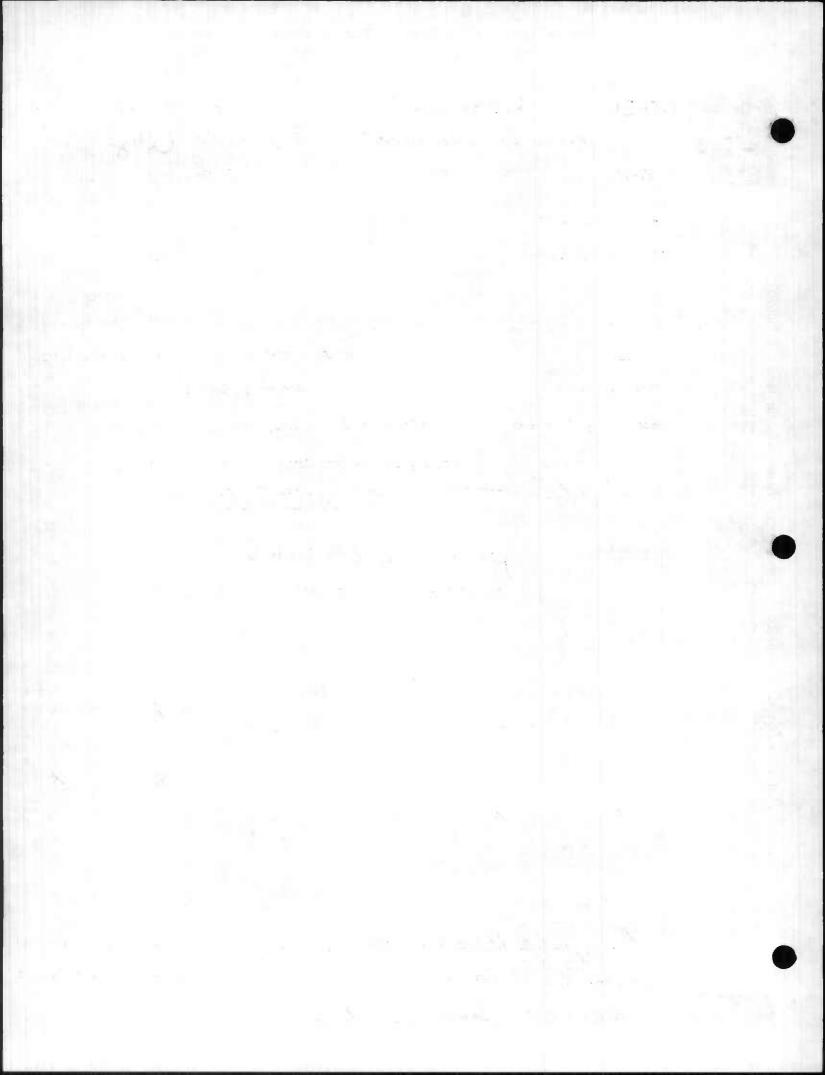
• Funeral Director: A pletely filled in by the fu death. 6 Could not be determined 3 ☐ Sulcide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner steted. 29a. Certifier Medical To the Fune (Check only one) within 2 29c. License number 7 462 46 29b. Signeture end title of cartifier 29d. Dete signed (Month, Day, Year) 30. Name and address of parson who com leted cause of death (Item 23a) (Typa, Print) M.D., 10 St. Patrick's Drive, Waldorf, MD 20603 M. ASHRAF MEELU. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State APR 13 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

| | | | | | Certi | ficate of | Death | | Reg. No. | 9 | 1443 |
|--|--|----------------------------|--|---|-----------------------|--|----------------------------|---|---------------------------------|--|--|
| Dhysisian | 1. Decedent's Nama (First, M | fiddle, Last | | | , | | | 2. Date of D | Death Dev | Year | 3. Time of Death |
| Physician /Medical | ETHEL | | KOBE | PRIS | 010 | | | APRIL | | 1999 | 5:30 AW |
| Examiner | 4a Facility Name (If not insti | | | | IMAR | E | | or Location of Dec | | ty of Deeth | |
| Funeral | 5. Social Security Number | 6. Se | x 7. | Age (In yrs. lesi | t birthdey) | If Under 1 Year | If Undar 24 | | | Birthp | lace (Stete or Foreign |
| Director | 215-20-1434 Usual Residence of Deceder | | M 2DF | 80 | Yrs. | July 5 | 1,0010 | July 2 | 8, 1918 | | PA |
| ww mand | 10a. Stete 10b. Co | | | 10c. City, T | Town or Local | tion | | | | 1 | 0d. Inside City Limits |
| h the Marylan or 28a-1 ahow or stathed a | MD Wie | comic |) | Sa | lisbur | У | | | | | 1X Yas 2□No |
| = 0 = 0 | 10e. Street and Number 504 W. Isabe | ella s | St. | | | 10f. Zip Code 218 | 301 | | 10g. Citizen of | | try? |
| | | Married | 12. Was Decede Armed Forca 1 Yes 2[If Yes, Give Yaar or Date | is? <mark>∑</mark> tNo | | s Decedent of es, specify Cut Yes 2 No | | n? (Specify Yas or P Puarto Rican, etc.) | Ble | ack, White, whit | etc. |
| 21215-002 ed within 72 hours or ygiens. ger then "natural", co ft, the Medical Exer Completed by | 15. Dec | dent's Edu | cation | 1 | 16a. Deceder | it's Usual Occu | pation during most o | f working | 16b. Kind of I | Business/Inc | dustry |
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| iore, Maryland 212: ges 1 end 2 should be filed withit t of Health and Mental Hygiens. If filem 27 is merked other than or other traumetic event, the M To Be Comp | | idia (ast) | | | | Hous | ekeepe: | C Name (First, Midd | | | amilies |
| Maryland d 2 should be file d 2 should be file file and Mental Hy 71s merked oth traumatic event | 1 | | | | | | | er Dashie | | | |
| should Ind Men and Men and Men and Men and Men and Men and Men and Men and and and and and and and and and an | 19a. Informant's Name/Rela | | /pe, Print) | | 19b. Mailing | Address (Stree | | or Rurel Route Num | | n, Stete, Zip | Code) |
| e, Meath at Heal | Donald McCoy | West/ | son | | 504 W. | Isabel | la St. | Salishu | rv. MD 2 | 1801 | |
| Baltimore, North Pages 1 and semit. Pages 1 and semit mortant: If Item 27 and Injury or other units. | 20a. Method of Disposition | | | | e of Disposit | on (Neme of tory or other pic | ace) | , Salisbu Dete | 20c. Location | - City or To | wn, Stete |
| Pages nent of I | Burial 2 ☐ Creme 4 ☐ Donation 5 ☐ Other | | | ite | | , | | ns 4/10/9 | 9 Salis | hurv | MD |
| Baltimo pemit. Pag Depertment Importent: h any Injury o | 21. Signature of Funeral San | vice Licens | 66 | | 22. 1 | lame and Addr | ess of Facility | | | Lucy, | 110 |
| a a a a a a a a a a | 1 M | 0 | and the second s | gate policifilm (ii) if energing χ_{0} , | | | | Funeral Salisbury | | 01 | |
| Physician /Medical Examiner | 23a. Part1. Enter the diseas shock, or heart failure. tmmediate Cause (Final disease or condition resulting in death) | e, or compl List only o | a. pu | Lmor | nary s e conseque | esv ince of): | | | errest, | 1 | Approximate therval Between Onset and Death |
| nsit name | | • | 01 | Jania | m | Carl | cer | | | | |
| \$8760, crate be executed physician end s the burial-transit edical Examir | Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury | | | Due to (or a | s a conseque | nce of): | | | | | |
| M Sas | | 1 | d | Dua to (or as | s a conseque | nce of): | | | | | |
| Beth for I | Part II. Other significant cor | ditlone | ntributing to deat | h but not reculting | ng in the und | advina cauca a | iven in Part I | 23h Di | d tobacco usa c | ontribute to | the cause of death? |
| trha de trha de tached | ratti. Other significant con | ditiona co | itilibuting to death | II Dat Hot 165attii | ng in the uno | silyalig cause g | Well III F GILL. | | yes 2 No | | |
| | | | | - | | | | | | | |
| requirements been should | | | | | | | | 24a. We | as an autopsy rformed? | av. | ere autopsy findings eileble prior to impletion of cause death? |
| I Relay The lay page 2 | | | | | | | | 1[| Yes 2 No | 10 | Yes 2 No |
| f Vital I yalclan: The yalclan: The is certificate director, page Co | 25. Was case referred to me examiner? | - | | | 10.11 | | 26. Plece o | Deeth (Check onl | y one) | | |
| - X S D | 1 ☐ Yes 2 No | | Hospital: Inp | | ?/Outpetient | 3LI DOA | | ing Home 5□ Re | | | y) |
| Division of teal or Attending P rs after death. al Director: After ted in by the funers Certification: | Z LI Accident | estigetion | 28a. Date of t (Month, | Dey Year) | Bb. Time of Injury | 28c. Inji W | uryat ork?]Yes 2∐No | | e how injury occi | | |
| Division Anter de Directe din by t | 3 Suicide 6 Co | ould not be termined | | Injury - At home , etc. (Specify) | e, farm, stree | f, factory, office | | 28f. Location City or 1 | (Street end Nun fown, Stete) | n <i>ber or R</i> ure | il Route Number, |
| Hospi 4 hour Funer tely fill | 29a. Certifier 15 Certifier (Check only one) 2 Med | | | s of examination | | | | place, and due to the occurred at the time | | | |
| To the within 2 To the comple | | rtifiar | To Us | Pepma | enm | Λ - | osa number | 7 | 29d. Data sign | | Dey, Year) |
| 6 | 30. Neme and eddress of pe | JO | ompleted cause of | of deeth (Item 23 | 3a) (Type, Pr | int) | 51 | NAI HO | | | BALTIMORE |
| State Registrar | 31. Date filed (Month, Dey,) | | | istrar's Signetur | | Som | L. | | | | 1 |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Deeth Month Vance I. Richardson 4 99 8:45 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Calvert Manor Healthcare Facility Rising Sun If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 100 M 2□ F 193-14-8738 87 Yrs. 10-19-11 VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 Lancaster 449 Daisy Drive, New Providence, PA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 449 Daisy Drive 17560 * USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2∑ No if Yes, Give Yeer or Dates: 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2XXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry during most of working Elementery/Secondary (0-12) College (1-4or 5+) 12 Farmer Agriculture 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George Richardson Fannie Roland 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Naomi J. Richardson 449 Daisy Drive, New Providence, PA 17560 20b. Pleca of Disposition (Name of cametery, crematory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from State -12 - 994 ☐ Donetion 5 ☐ Other (Specify) Little Britain Presby.Cem. Fulton Twp, PA 21 Signature of Funeral Service Ligarisms 22. Name end Address of Fecility Reynolds Funeral Home, Quarryville, PA 17566 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete rvel Betwe Onset end Deeth Immediate Cause (Fine) disease or condition resulting in deeth) entrovascular Due to (or es e consequence of): Years SQVD, Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medicai Examiner

attending physician and for use as the bunel-transit

the

been signed by should be detac

hes page 2 certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

by

Completed

Be

Medical Certification: To

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

6

Herns 23a

"natural", or

permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'n any injury or other traumatic event, tra Med once.

the

death

72 hours efter

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

traumatic event, the Medical Examiner must be notified at

Examiner Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last Physician/Medicai

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending Investigation 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and menner es stated. 29a, Certifier

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

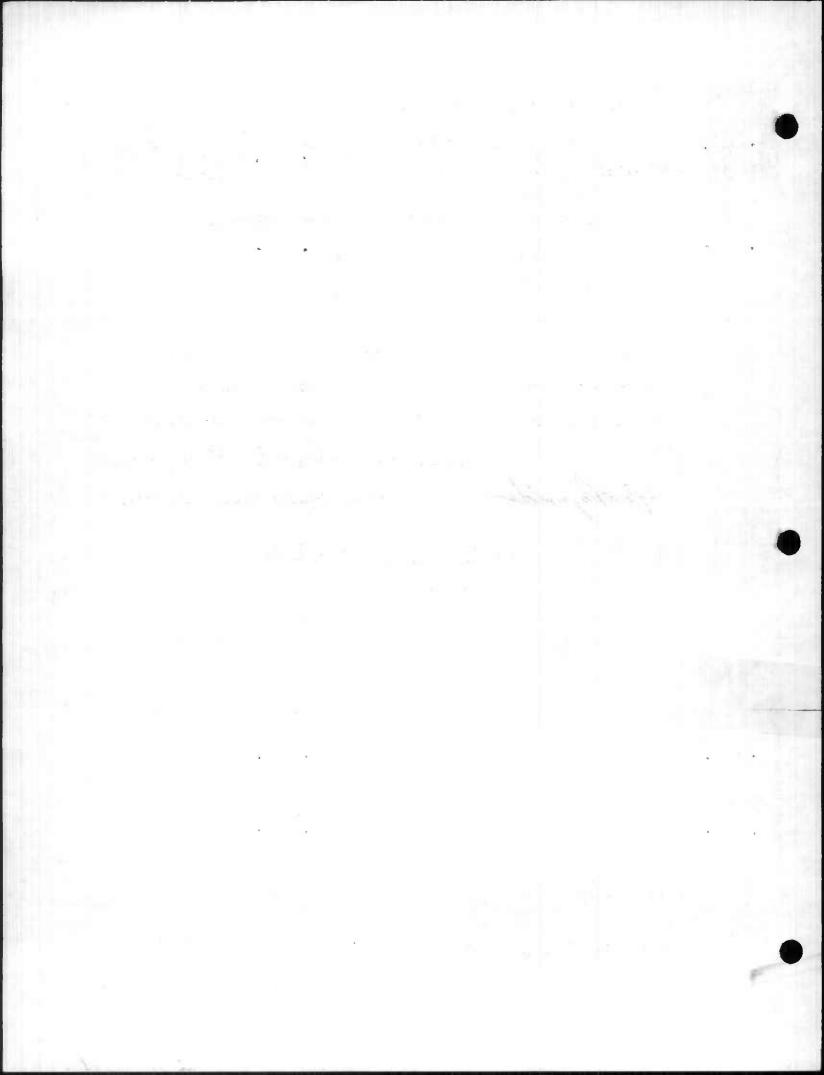
29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

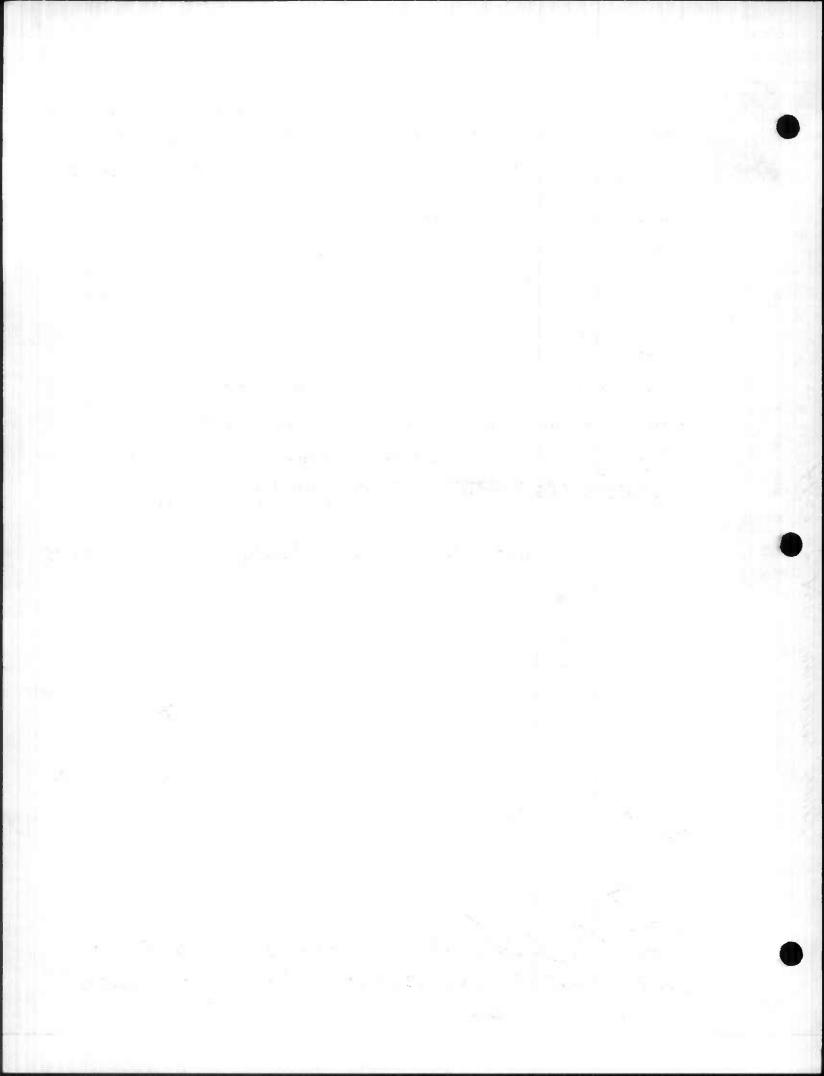
Calvert Healthcare Center Rising) onlin Y MD 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene 🎧 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3 Time of Death Sauerbrunn **Physician** 1133 Mine April /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth SALISBURY Examiner 4c. County of Deetle WICOMICO PENINSULA REGIONAL MEDICAL CENTER | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | 06 (Month, Day) | Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 9. Birthpleca (State or Foreign 1□ M 2 F 73 filinois Yrs. Director 354-20-0594 Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Yes Z No Sussex Delaware Seaford 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 904 Robin Dr 19973 US Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritai Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 N Married 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 21215-0020 þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Eiementery/Secondery (0-12) College (1-4or 5+) Homemaker Pages t and 2 should be filed v nent of Health and Mental Hygie int: If Item 27 Is marked other t Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Roy J. Boyd Imogene Byrd 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health a H ham 27 is or other tra Robert Sauerbrunn - husband 904 Robin Dr, Seaford, DE 19973 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burlel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any Injury or Del. Veterans Cemetery 21 Signature of Funeral Service Licensee 04/06/99 Bear, DE 22. Name end Address of Fecility
Cranston Funeral Home unstoo P O Box 967, Seaford, DE 19973 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es e consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown signed by à funeral director, page 2 should be Be Completed 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was an eutopsy performed? this certificate or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes inpatient 2 ER/Outpatient 3 DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred After Naturel 5 Pending death. 2 Accident investigetion 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner state. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Salish MD E. Conall, MD 145E. David 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State APR 0 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** April 8, 1999 Emma Sullivan 8:00 AM Pauline /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF 79 217-10-3643 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yas 2 No Director Md. Worcester Snow Hill 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21863 U.S.A. Berns 23a Funeral Pleasant Manor, Church Street 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Wicomico Board of Elementery/Secondary (0-12) College (1-4or 5+) Food Service Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be III ment of Health and Mental H anti: If them 27 is marked oth lury or other traumatic even Be Robert Collins India Anna (unknown maiden name) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7007 Mt. Olive Church Rd., Snow Hill, Md. 21863 Indiana P. Shockley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/11/99 Powellville, Md. Powellville Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 ennes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final /Medical disease or condition resulting in death) alune Examiner Due to (or as a consequence of): Examiner lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2440 3 Probably 4 Unknown bengis Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. 25. Wes case referred to medicat examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 10 Netural 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) within 2 945 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins, M.D. 1104 Healthway Dr. Salisbury MD Q1804 illiam

Registrar

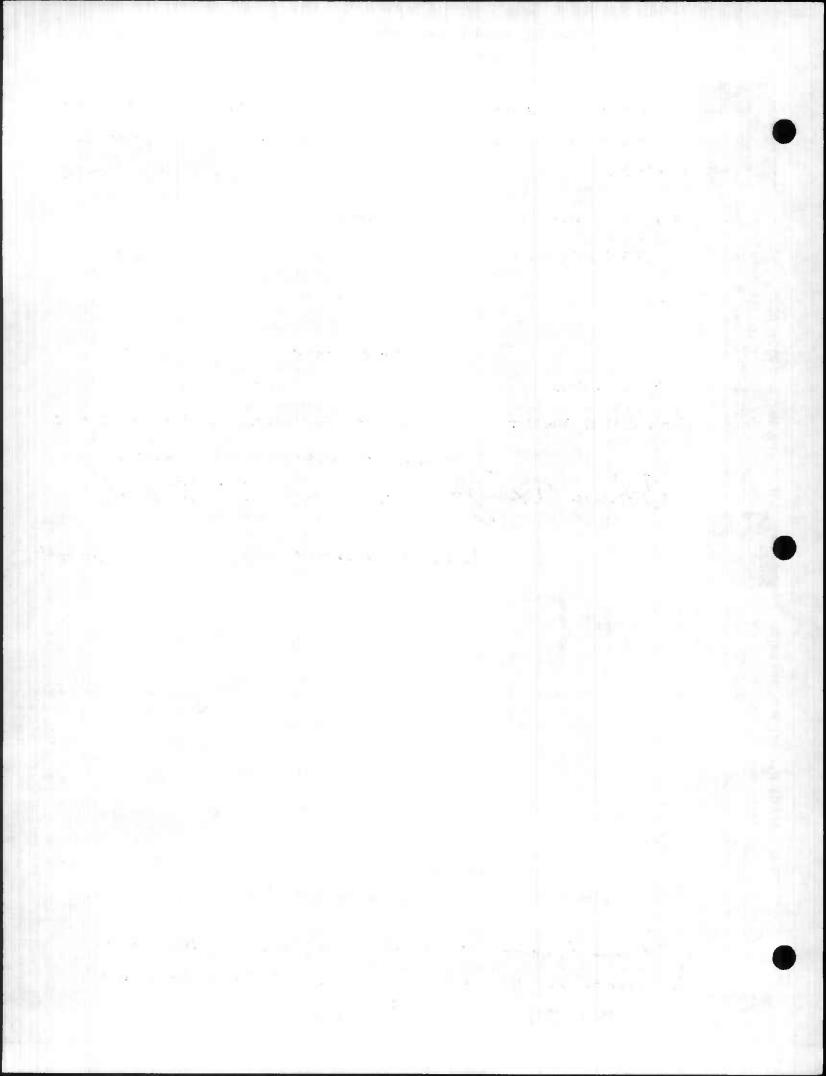
State

32. Registrar's Signature

502 8 TW

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Certific | ate of L | Jealli | | Reg. No. | 1 | Charles A. |
|---|--|--|---|---|--|---|--|--|--|--|--|
| Dhualaian | 1. Deceder | nt's Neme (First, Middle, La | est) | | | | | 2. Date of De | ath Day | Year | 3. Time of Deeth |
| Physician - /Medical | | Delmar S | parkman | | | | | April | 6 | 1999 | 7:30PM |
| Examiner | | Neme (If not institution, given | | | | 4 | | Location of Deet | | y of Death | |
| | 14 | 804 Mud Coll | ege Rd. | | | | Thurmon | | F | reder | |
| Funeral Director | | | Sex 7. Ag | ge (In yrs. las 73 | t birthdey) If Ur Yrs. Mont | ths Deys | If Under 24 Hrs Hours Min | 8. Date of Big (Month, Da Jan . I | th Yeer 1926 | 9. Birthr Cour Ken | place (Stete or Foreignty) |
| | | dance of Decedent | | 1 | | | | | | | |
| how | 10a. State | 10b. County | | 10c. City, 1 | Town or Location | | | | | 1 | I Od. Inside City Limit |
| ot ot | Maryl | and Frede | rick | | Thu | rmont | | | | | 1 ☐ Yes 2 1 N |
| 128 I'e | 10e. Street | and Number | | • | 101. | Zip Code | | | 10g. Citizen of | What Cour | ntry? |
| 9 9 | 14 | 804 Mud Col1 | ege Rd. | | | 217 | 788 | | U. | S.A. | |
| 182 | 11. Maritel | | 12. Was Decedent | | 13. Was De | ecedent of H | ispanic Origin? (| Specify Yes or Norto Rican, etc.) | - 14. Ra | ce - Americ | |
| which is four after decid with the maryand than "natural; or items 23s or 23s-1 show he Maddell Examiner must be notified at by Puneral Director | 1 □ Ne | ver Married 2 Married | Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates: | | | specify Cube as 2 1 No | | rto Rican, etc.) | Specia | rck, White, Wh: | elc. ite |
| ygiene. Northan "natural", nt, fre Medical Earl Completed by | | 15. Decedent's E | ducetion | | 16a. Decedent's U | Usuel Occupa | ation | 4. | 16b. Kind of E | Business/In | dustry |
| Die o | Flancing | (Specify only highest gr | | 5.0 | (Give kind of lifa. DO NO | f work done of Tuse ratired | furing most of wo f) | orking | | | |
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| tal Hygiene. d other than event, trail Be Comp | 17. Father | s Name (First, Middle, Last |) | | | | 18. Mother's Na | me (First, Middle | Maidan Sume | тө) | |
| E SE | | D. Sparkman | | | | | Isab | elle Fra | zier | | |
| marke umarke | | | | | 401 14 11 14 14 | (0) | | | | Contr. Ti- | Codel |
| 0 9 6 | | nant's Name/Ralationship | | | | | | Rural Routa Numb | | | |
| f Heelth form 27 other tr | - | Jensen/ dau | ignter | | 37 Catoc | | | | | | |
| 2 = 2 | 1 🗆 B | od of Disposition uriel 2 ☐ Cremetlon 3 ☐ onation 5 ☐ Other <i>(Speci</i> | | | ce of Disposition (netery, crematory haven Me | | | Date 4/9/99 | Freder: | | |
| Department of important: If any injury or page. | 21. Signal | re of Foneral Service Lice | O. Wart | Der | | e end Addres | in St. | artzler : | Funeral oro, MD | | 8 |
| | 230 Port | | aplications that aug | the death | | | | | | 211) | Approximeta |
| 10000 | shoc | . Enter the disease, or com k, or heart failure. List only | one cause on each li | ne. | | ,,,,, | | | | | Interval Between Onset end Deeth |
| hysician | | 0 (5) | | | | - | | | | | |
| /Medical xaminer | disease or | Causa (Final condition | . (| - 1 V | er (| Canc | ev | | | 10 | 6 months |
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| C.8 W | if any, lead | ding to Immediate | | | | | | | | | |
| sicien e burie cal E | if any, lead cause. En Causa (Dis that Initiate | lly list conditions, ding to Immediate ster Underlying sease or Injury and events | C | Due to /or a | e a consequence | | | | | | |
| physicien end is the buriel-transit edical Examir | I that mittate | ding to Immediate ster Underlying saasa or Injury and events in death) Last | С | Due to (or a | s a consequence | | | | | | |
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| as the bu | resulting in | ed events | d | Due to (or a | s a consequence | | | | | | |
| as the bu | resulting in | ed events | | | | of): | en in Part I. | 23b. Did | tobacco usa c | ontributa t | o the causa of deal |
| as the bu | resulting in | d death) Last | | | | of): | en in Part I. | | tobacco usa c Yes 2□ No | | o the causa of deal |
| as the bu | resulting in | d death) Last | | | | of): | en in Part I. | | | 3 Pro | bably 4 Unkno |
| igned by the ettending physicis be detached for use as the but by Physician/Medical | resulting in | d death) Last | | | | of): | en in Part I. | 1 X | | 3 Pro | bably 4 Unknowa Unknow |
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| certificate has been signed by the ettending physicis riector, page 2 should be detached for use as the but Be Completed by Physician/Medical | Part II. Oth | er elgnificant conditions of the conditions of t | contributing to death b | out not resulti | ng in the underlyi | of): ing ceuse giv | 26. Placa of Do ar: 4 ☐ Nursing | 24a. Was peri | Yes 2 No an autopsy med? Yes 2 No one) | 3 Pro | fara autopsy finding: vailable prior to mpletion of cause daeth? ☐ Yes ☑ No |
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permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Depertment of Health and Mentel Hygiene. The Permitter of the standard of

15年317-38-4717

George Sheckley 553
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

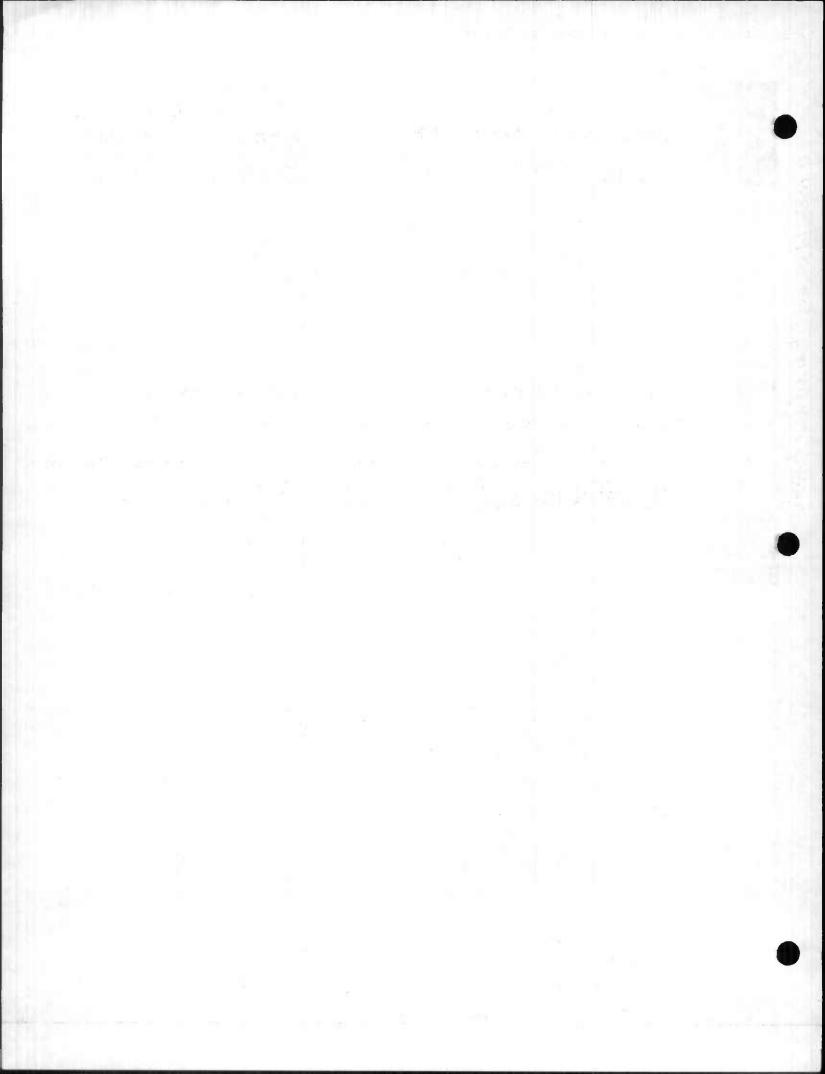
State of Maryland / Department of Health and Mental Hygiene

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| | | | | | | Cer | tificat | e of | Death | | | Reg. No |). | | 9 4 4 0 | |
|-----|--|--------------------------------|---------------------------------|--------------------------|---------------|------------------|---|------------------|-------------------|-----------------|---------------------------------|-----------------|-------------|------------------|--|-----|
| | 1. Decedant's Nama | (First, Middle, | Last) | | | | | - | | | 2. Date of De | | | | 3. Time of Death | h |
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| | 5. Sociei Security Nu | mber | 6. Sax | 7. Aga (In) | yrs. last bir | thday) | If Under Months | 1 Yeer Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, Di | rth av. Year | | 9. Birthpi | ace (State or Fore | ign |
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| 1 | 10e. Street and Num | | | | | | 10f. Zip | Coda | _ | | 1 | 10g. Cf | tizan of W | /hat Count | try? | |
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| | 11 | | | | | Own | ner | | | | | Tax | i-Ca | b Con | npany | |
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| | William 1 | Frankli | n Shockl | ev | | | | | T1 | ida 1 | Leona S | hock | lev | | | |
| f | 19e. Informent's Nar | | | -1 | 19b | . Mailin | g Addrass | (Street | | | ral Route Numb | | | State. Zin | Code) | |
| 1 | Gary F. | | | | | | | | | | ury, MD | | | | , | |
| 1 | 20a. Method of Dispo | | A (DOII) | 90 | b. Piace of | | | | , sal | TTDDI | Deta | | | City or T- | um Cteta | |
| 1 | 1 ☐ Buriai 2 ☐ | Cremetion | 3 Ramovai from | Stata | cemete | ry, crem | atory or o | ther plac | ce) | i | Deld | 200. L | ocalion • ! | City or To | mii, Gidle | |
| 1 | 4 Donetion | 5 XOthar (Sp. | ecify) entarian | | icamia | o Mer | morial | Park | 2 | 4 | 1/5/99 | Sal | isbu | ry, M | Maryland | |
| | 21. Signature of Fun | | | M010 | | 22. | Nama an | d Addra | ss of Facili | ty | | | | | | |
| - | The last | 11/11 | ta === | | | | | | | | me, P.A | | | 04.5.5 | | |
| + | 23a Part1 Enter the | e disease or o | omplications that | | leath Do | 50 | I Sno | w Hj | LII RO | oad, | Salisb | ury, | MD | 21804 | 4 Approximata | |
| l | 23a. Part1. Entar the shock, or haert | tailura. List o | nly ona ceuse on | each line. | addin. Doi | iot ainte | ii iila iiloo | a or ayar | 19, 3001 93 | Cardiac | or respiratory e | niost, | | | tntervei Between Onset end Deeth | |
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| ı | tmmediate Ceuse (F diseesa or condition | | A | -6 | lere | les | 1/ | uln | au | 1 | dono | 2 | | 1 | RMs. | |
| l | rasulting in daath) | | 0. | Dua t | o (or es e | conseq | uarice ot): | -20 | / | | | | | | | |
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| | Causa (Disease or in that initiated avants | njurý | c | Due to | o (or as e o | Oneers | iance of). | | | | | | | - | | |
| | resulting in death) La | ast | | D09 (| - (0, 83 6 (| Jonabyt | ano on. | | | | | | | ! | | |
| 1 | | | d | | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | i | | |
| | Part II. Other signific | ant condition | s contributing to d | eath but not | rasulting in | n tha un | darlying c | eusa giv | en in Pert I | L | 23b, Dtd | tobacco | use con | tributa to | the cause of dea | th? |
| 1 | No | 21000 | Conno | X | 1 | 200 | / | | - 4 | | 12 | Yes 2 | 2 □ No | 3 Prob | abiy 4 Unkn | own |
| 1 | | reek. | rige | SUL | (0 | 100 | why | 1 | alky | | | | | | | |
| 1 | - 1 | 5,/ | 1 | 10 | 0 | 1 | 10 | | 1 | 0 | 24a. Was | an auto | psy | ava | ra autopsy tinding allable prior to | S |
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| 1 | 1 Tas 2 N | 10 | 114 | | 2 ER/Ou | | | JA | 4 LI NI | ursing Ho | oma 5 Rasi | | | |) | |
| | 27. Manner of Death | 5 Panding | 28a. Data (Mon | of Injury th, Day Yea | | Tima of njury | | 8c. Injur Wor | | | 28d. Dascribe | now inju | ry occurre | 9d | | |
| | 2 Accidant | invastiga | ation | | | | М | 1 🗆 | Yas 2 | No | | | | | | |
| | 3 ☐ Suicide 4 ☐ Homlcida | 6 Could no datarmin | and 288. Place | of Injury - A | At home, fa | rm, stra | at, factory | , office | | | 28f. Location (| Street al | nd Numbe | or Aura | Route Number, | |
| | · ad i remining | | Sulid | | oury/ | | | | | | Jay 01 10 | , Otali | -/ | | | |
| f | 29a. Cartifiar | Certifying | Physician: To the | best of my | knowiedge | , daeth | occurred | at tha tir | na, data an | nd place. | and dua to tha | causa(s |) and mar | nnar as st | ated. | |
| | (Check only 2 one) | 2 Madical E | xaminar: On tha b | asis of exem | ninetion an | d/or inv | astigation | , in my o | pinion, das | th occur | red at tha tima, | data an | d plece, a | nd dua to | the ceuse(s) | |
| f | 29b. Signatura and ti | itia of certifiar | 1 | | | - | 290 | . Licans | a number | | | 29d. Da | ıta signed | (Month, I | Day, Year) | |
| | | > | | | 11 | | | 10 | | | | | 11 | 1 | | |
| 1 | 1 | Lesus | 20 | . / | 10 | au | ey | 1) - | -20 | 05 | 0 | 7 | 111 | 99 | | |
| | 30. Nama and address | ss ot person w | no completed ceu | sa ot death (| Itam 23a) | (Type, F | Print) | _ | ^ | | 2 ^ | | . 1 | 1 . | | |
| | \mathcal{B}_{i} | ENITE | 5. | CHA | U | 54 | 47- | 6 | Rins | wsio | le A | - 6 | Sale | 36 | ,402/ | e |
| | 31. Dete tiled (Month | Dey, Year) | | Registrar's Si | ignature | | | - | - | | | | | // | 6 | 10 |
| I | Al | K 02 | 1999 J | Gener | 4 | 4 | | | | | | | | | | |
| aL. | | | | | - | | Pape | out | 2 | | | | | | | |
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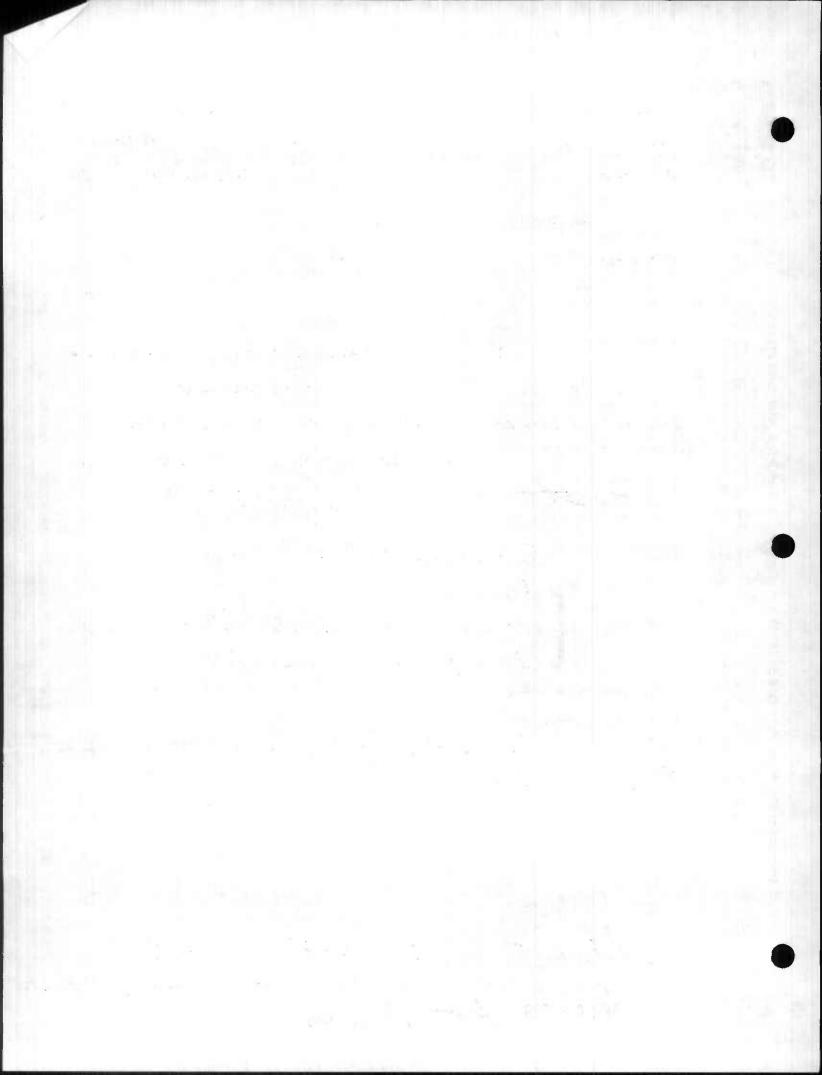
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State of Maryland / Department of Health and Mental Hygiene ()

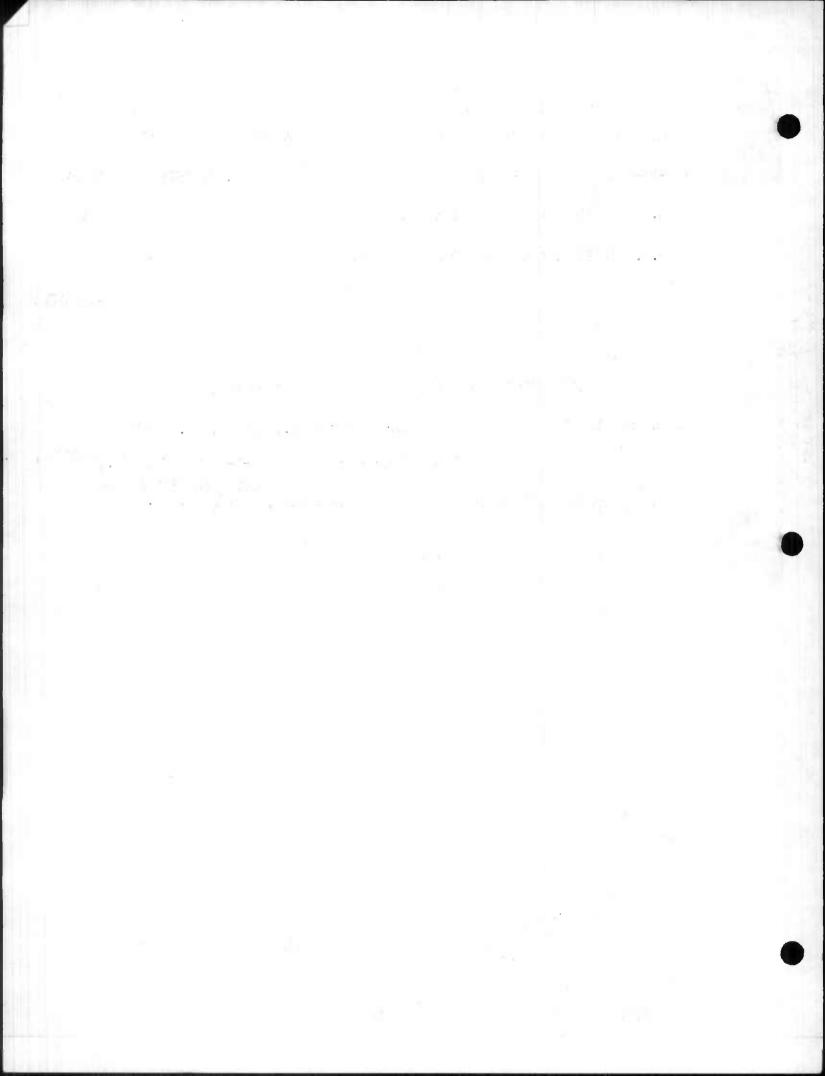
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Jacqueline D. Taylor 1999 1005 April 05 /Medical 4a Facility Name (if not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4324 Tower DRive Snow Hill Worcester If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (in yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months Davs 1 M 2 X Yrs. Director 219-84-3622 36 July 12, 1962 MD Usual Residence of Deceden with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Example, must be notified at 1 Yas 2 No Director Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4324 Tower Drive 21863 U.S. Funeral death 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) correctional officer law enforcement permit. Pages 1 and 2 should be filled. Department of Health and Mental Health and Mental Health and July or other 27 is meany injury or other. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Alice T. Shrieves Henry T. Bishop, Sr. 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kevin B. Taylor/husband 4324 Tower Drive, Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Wesley UMC Cemetery 4/10/99 Snow Hill, MD 21. Signature of Funeral Sarvice Licensey 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner monta physician and the bunal-trans Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dueup for as a consequence of P.O. Box 68760, Physician/Medical for usa as ronall signed by the a d be datached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Diff tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy cartificate has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical axaminer? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 3 DOA 1 Inpatient 2 ER/Outpetient After this 27. Manner of Death funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending investigation after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. edical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and dua to the cause(s) end menner steted. To the Vithin 2 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Roun t St. SnowyHill, Mp 21863 106 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura APR 08 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene \(\)

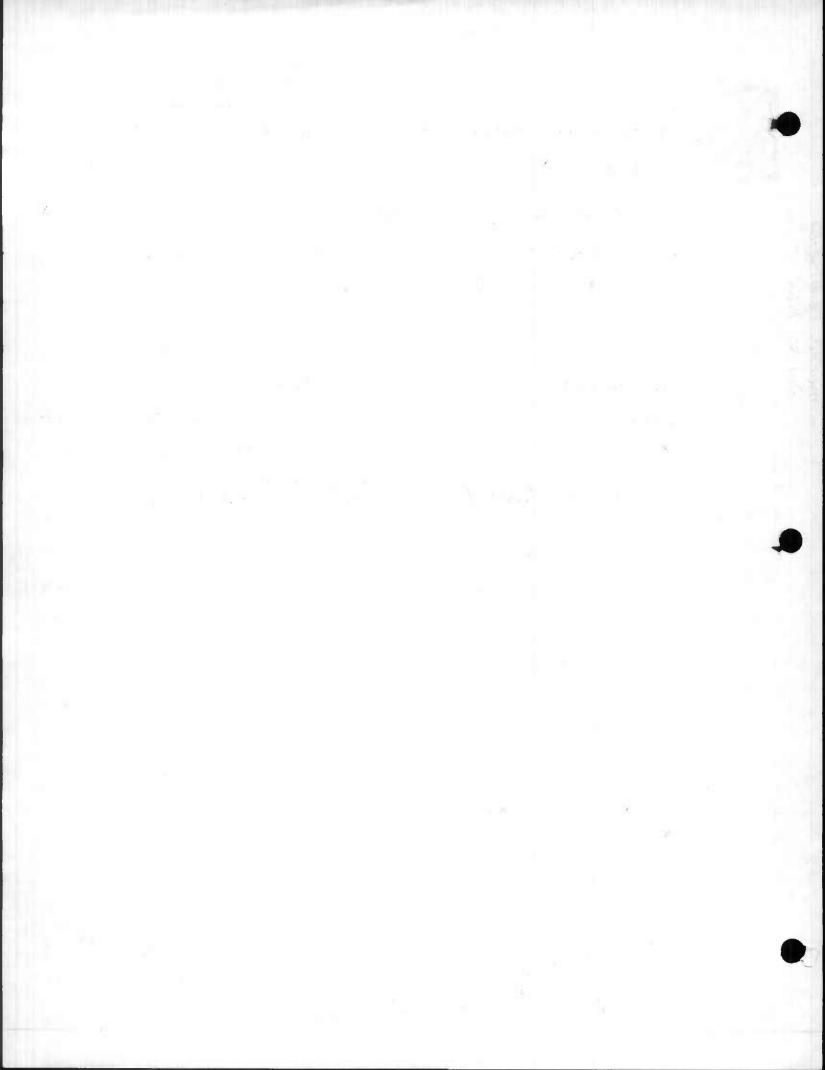
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|----------------|--|---------------------|---|---|---|---------------------|--|---|--|------------------------------------|---|---|
| г | Physic | ian | 1. Decedent's Neme (First, Middle, | Last) | | | | | 2. Dete of D Month | eeth Dev | Year 3. | . Time of Deeth |
| | /Medi | | | CLARISA | | | | | APRIC | - 5, 15 | 55 6 | 0005 |
| | Exami | ner | 4e. Fecility Neme (If not institution, PENINSULA REGI | | , | ER | | SALI | or Location of Dea ISBURY | W | y of Deeth ICOMICO | |
| | Funeral Director | | 5. Social Security Number 217-86-9646 Usuel Residence of Decedent | 1 M 2 TE | Age (In yrs. lest i 26 | | If Under 1 Year Months Deys | If Under 24 F Hours N | Hrs. 8. Dete of Bi lin. (Month, D MAR. 3 | rth ey, <i>Year</i>) 1973 | 9. Birthplece Country) SALISE | (State or Foreign |
| | land w | | 10e. Stete 10b. County | | 10c. City, To | wn or Loca | ntion | | | | 10d. f | Inside City Limits |
| | a-f sh | ctor | MD. WICC | MICO | SALI | SBURY | | | | | | Yee 2□No |
| | or 28 | Dire | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of | Whet Country? | |
| | ath w | rai | P.O. BOX 2358 | | | | 21802 | | | USA | | |
| 21215-0020 | be filed within 72 hours after death with the Maryland Ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinating the incitied at | by Funeral Director | 11. Manital Status 1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced | 12. Wes Deceder Armed Force 1 | s? Û No | | as Decedent of H res, specify Cub | lispenic Origin? en, Mexican, Pu Specify: | (Specify Yes or N lerto Rican, etc.) | | ce - American Ir ck, White, etc. 'y: AFRO-A | MERICAN |
| 2-0 | 72 h | eted | 15. Decedent's (Specify only highest | Education prede completed) | 18 | e. Deceder | nt's Usuel Occup | etion during most of t | working | 16b. Kind of B | usiness/Industr | у |
| 121 | within | Completed | Elementary/Secondary (0-12) | College (1-4c | | life. DC | NOT use retire | d) | | | | |
| d 2 | Hygie Hygie ont, II | | 5th 17. Fether's Neme (First, Middle, La | st) | | N/A | | 18. Mother's h | Neme (First, Middle | | /A | |
| Maryland | 2 should be filed end Mental Hygi is marked other aumatic event, to | To Be | LOCKWOO | , | (FATHER |) | | | NDA SHOCK | | , | |
| ary | s marked | F | 19e. informent's Neme/Reletionship | | | | Address (Street | | Rurei Route Numi | | , Stete, Zip Coc | le) |
| | s 1 and 2 should f Health end Mer tam 27 is marke other traumatic | | LOCKWOOD TINGLE | | | | | | | | · | |
| ore | of He Itam | | 20e. Method of Disposition | | Cerrie | erv. creme | tory or other bies | 207 | DELMAR, | | | |
| Ĕ | Peg nent ant: H | | 1 ☐ Buriel 2X☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe | | SALI | SBURY | CREMATO | DRY | 4-5-99 | SNOWHIL | I RDSAL | ISBURY, |
| Baltimore, | permit. Peges 1 and Department of Health Important: if item 27 any Injury or other tr | | 21. Signature of Figheral Service Lin | ensee B. C | lles | 22. N | Neme end Addre | ss of Facility | JOLLEY ME , SALISBL | MORIAL | CHAPEL | |
| | Physician | | 23a. Part1. Enfer the disease, or co shock, or hyart failure. List or | mplications that caus ly one cause in each | ed the death. D | o not enter | the mode of dyir | ng, such es card | liec or respiretory | errest, | App | proximete ervel Between set end Deeth |
| | /Medical Examiner | | Immediate Ceuse (Finel disease or condition | | Pru | mon | ia | | | | 11 | ンド |
| | - Adminion | h | resulting in death) | • | Due to (or es | | | | | | 1 | C |
| | ted nsit | in in | | b | | 220 | | re | | | L | ire |
| o, | icete be executed physician end s the buriel-trensit | Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury | | Due to (or es | | nce of): | Hon | | | | ₂ 1 |
| 68760, | hysici | Medical | thet initieted events resulting in deeth) Lest | C | Due to (or es | | | | | | | |
| 9 X | certificete Iding physi | | | d | Cere | المعرط | Palse | 1 | | | | 1 |
| Box | death cer e ettendir ed for use | Physician/ | Pert II. Other significant conditions | contributing to death | but not resulting | in the unde | arlying cause giv | en in Pert I | 23b Did | tobecco use co | intribute to the | cause of death |
| 0.0 | res thet the de signed by the e be deteched i | | | | | | | | | Yes 2 No | | y 4 Unknow |
| Vital Records, | been s | Completed by | | | | | | | 24e. Wes | s en eutopsy ormed? | aveilabl | outopsy findings le prior to ution of cause |
| R | 0 - 5 | E O | | | | | | | 1 🗆 | Yes 2 No | 1 □ Ye | |
| ā | certificate | BeC | 25. Wes case referred to medical | | | | | 26. Piece of [| Deeth (Check only | | 1 | . 23-110 |
| > | 5 00 | TOE | exeminer? 1 ☐ Yes 2 X (No | Hospital: Vinpa | tient 2 ER/C | Outpetient | 3□ DOA Oth | or. | g Home 5 ☐ Res | | ner (Specify) | |
| | Attending Ph or death. ector: After th by the funeral | 1 1 | 27. Menner of Deeth 1. Returner 5 Pending investigat | 28a. Dete of in (Month, L | | . Time of Injury | 28c. Injur Wor M 1 | y et k? Yes 2 □ No | 28d. Describe | how injury occur | red | |
| Division | tal or Atters of Directed in by t | Certification: | 3 Suicide 6 Could not determine | 28e. Pieca of I building, | njury - At home, etc. <i>(Specity)</i> | farm, street | t, factory, office | | | (Street end Numb wn, Stete) | per or Rurel Roo | ute Number, |
| | To the Hospital or / within 24 hours efter To the Funeral Dire completely filled in b | edical | 29a. Certifier (Check only one) 1 ☐ Certifying 2 ☐ Medical Ex | Physicien: To the best eminer: On the basis end menner: | of exemination e | ge, deeth o | ccurred at the tir stigation, in my o | ne, dete end pla pinion, deeth oc | ace, and due to the courred et the time, | ceuse(s) end mo dete end placa, | end due to the | cause(s) |
| | vithin Vithin To the | Me | 29b. Signature and little of certifier | | | | 29c. Licens | e number | | 29d. Dete signe | d (Month, Dey, | Year) |
| | | | M Lus | | | | HST | 7497 | | 41519 | 9 | |
| , | | × | 30. Name and address of person who Christopher & Mider | | death (Item 23e | (Type, Pri | int) | | burg, 1 | no | | |
| | Sta | ite | 31. Dete filed (Month, Day, Year) | 32 Regis | trer's Signature | 1 | fra L | | 0 | | | |
| | Registr | ar | APR 0 6 199 | y some | va / | 9 2 | bout | | | | | |



| | State Registra |
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| DHMH | 16 Rev 6/95 |

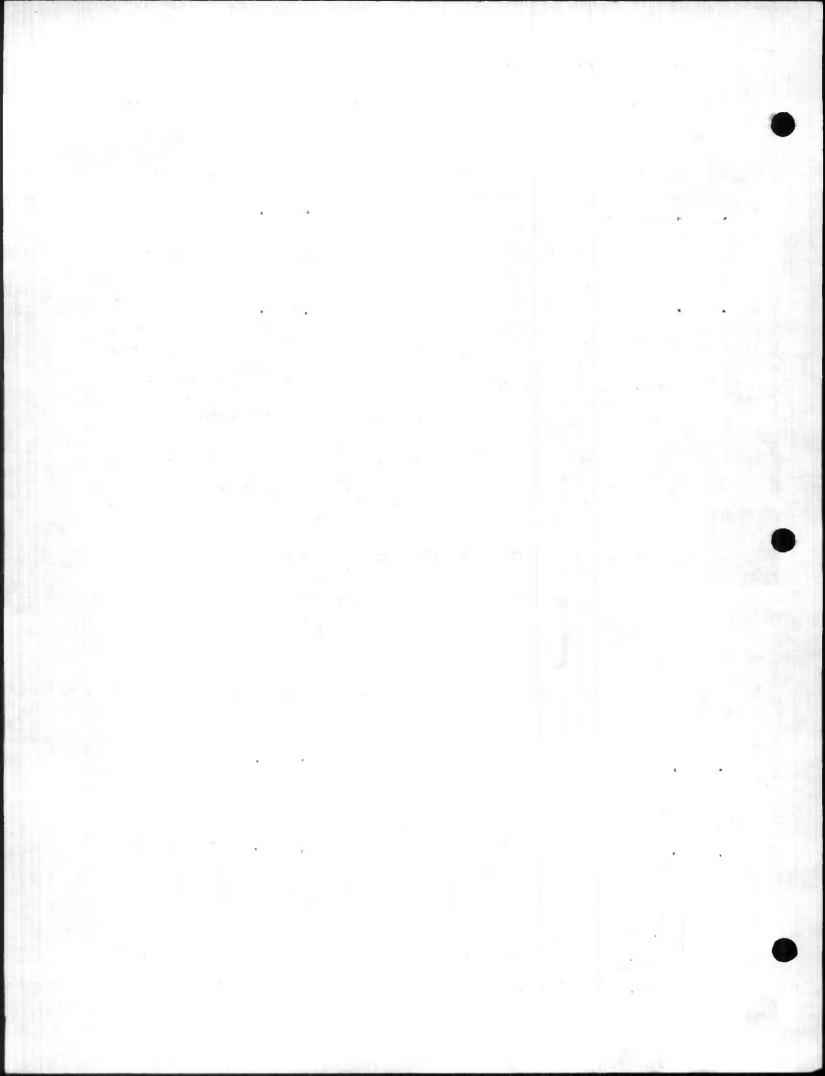
| | | | Please | Type or Prir State of Ma | | / Depa | | Health and N | | | ible. | 3451 | |
|-------------------|--|------------------|---|---|----------------------------|--------------------------|--|---|-------------------------------------|--------------------------------|--------------------------------|---|----------|
| П | Physici | an | 1. Decedent's Nama (First, Middla, La | | | | | | 2. Data of D Month | eeth Dey | Yaer | 3. Tima of Daeth | 1 |
| | /Medi | | Morris Cliffo | | send | | | # 6h Taur 1 | 4 | 4 | 99 | 0110 | |
| Ĺ | Examir | ner | 4e. Fecility Neme (If not institution, giv. PENINSULA REGION | AL MEDICAL | CENTE | ER | | 4b. City, Town, or L SALISBU | JRY | W | ty of Deeth ICOMIC | 0 | |
| Į. | Funeral Director | | 214-30-7000 | Sex 7. Age | a (In yrs. last | birthday) Yrs. | If Undar 1 Yaar Months Deys | | 8. Data of B (Month, D Mar. 2 | irth Pay, Year) 25 1931 | Count | aca <i>(Stata or For</i> a try) yland | ign |
| | and w. | | Usuel Residanca of Dacadant 10a. Stata 10b. County | | 10c. City, To | own or Lo | cation | | | | 10 | Od. Inside City Limi | its |
| | Maryi -f sho | Po | Maryland Wicon | nico | Sa | alis | bury | | | | | 1□Yes 2X | |
| | r 28a | Director | 10e. Straat and Number | | | | 10f. Zip Coda | | | 10g. Citizen of | What Count | try? | |
| | th wit | | 27495 Edgewood | Circle | | | 2180 |)1 | | U.S. | A | | |
| 0 | be filed within 72 hours after death with the Maryland that Hygiene. Id other than "netural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral | 11. Marital Status 1 □ Nevar Married 2 Married | 12. Was Decadant I Armed Forcas? 1 Yas 2 | | | | Hispanic Origin? (Sp ban, Mexican, Puarto | pacify Yes or No Rican, etc.) | o- 14. Ra Bl | ice - Amarica ack, Whita, a | | |
| 02 | ral', c | by | 3 Widowed 4 Divorced | If Yas, Give Yaar or Datas: | | | I□Yas 2 X No | Specify: | | Spec | Blac | ck | |
| 2 | 72 h | etec | 15. Decedant's Ed (Spacify only highast gra | ducation ida complatad) | 10 | 6a. Deced (Give | lant's Usual Occu kind of work done | ipation a during most of worked) | king | 16b. Kind of | Businass/Ind | ustry | |
| 21215-0020 | d within giene. rr than " | Completed | Elamantary/Sacondary (0-12) | Collaga (1-4or 5 | i+) | | oo NOT usa <i>retire</i> borer | ed) | | None | | | |
| D | ai Hygi I other | Bec | 17. Fether's Neme (First, Middla, Last) |) | | | | 18. Mother's Nem | ne (First, Middle | e, Meiden Sume | me) | | |
| yla | should be t and Mentai I marked of umatic eve | 2 | Emory Townsend | | | | | Daisy | Townse | end | | | |
| Maryland | N 00 00 00 | | 19e. Informant's Name/Ralationship (| | | | | at and Numbar or Rui | | | | | |
| | 1 an Heal | | Sheila Townsend | d (Daught | | | Duncar sition (Nama of | n Crossi | ng, wna | 20c. Location | | | |
| Mo | | | 1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Spacifi | | cema | tary, crem | Churc | | 4/9/99 | | | Office | |
| Baltimore, | permit. Pages Department of important: If i any injury or once. | | 21. Signatura of Funaral Service Lican | | 0 | | | ass of Facility Funeral | Home | | | | |
| | | _ | | Stewar | 1 | | | t Rd.Sal | | | 1801 | Augustinas | |
| | Physician | | 23a. Pert1. Entar tha disaasa, or com shock, or haert feilura. List only | one ceuse on eech lir | na daain. L | o not anti | ar tha moda of dy | ring, such es cardiac | or raspiratory | arrast, | | Approximete Interval Batween Onsat and Death | |
| - | /Medical Examiner | | Immadiata Causa (Final disaasa or condition resulting in daath) | . ACIDO | 313) | 2.000000 | ulance of): | | | | | 10 HRS | - |
| | D == | ner | | DIAS | Dua to (or as | a conseq | derice or). | | | | 1 | 10 4125 | |
| | a executed ian and unal-transit | Examiner | Sequentially list conditions, if any, leading to immediate | 0. | Dua to (or as | | uance of): | | | | | | |
| 760, | A 0 A | - | Causa (Disaasa or Injury that initiated avents | C | Dua to (or as | 1- | HS PU | | | | | 10 945 | |
| Box 687 | death certificate be e ettending physici ed for use as the bu | Physician/Medica | rasulting in daath) Last | d | | | | | | | | | |
| ă | death death | Iciai | Part II. Other eignificent conditions or | ontributing to death by | it not reculting | a in the ur | ndarhving cause g | ivan In Part I | 23h Die | tohecco use c | ontribute to | tha cause of dea | th2 |
| 0.0 | | | Tarrii. Onlor organicom conditions of | onthoding to death be | at not resoluti | g in the di | idanying cadaa g | real til all t | | Yes 2□ No | ********** | | |
| Records, | requi | Completed by | | | | | | | 24a. We | s en eutopsy formed? | con | are eutopsy finding bilable prior to applation of causa daath? | S |
| ř | The law cate has I | шо | | | | | | | 1□ | Yas 2 No | 1□ | Yas 2□ No | |
| Ta | | Bec | 25. Was case referred to medical axaminar? | | | | | 26. Placa of Daa | th (Chack only | one) | | | |
| > | 5 00 | 10 | 1 ☐ Yas 2 No | Hospital: 1 Inpatie | nt 2 ER/ | Outpatian | T 3LI DOA | | ome 5 Res | sidence 6 🗆 O | thar (Specify | ') | |
| Division of Vital | of the | atlon: | 27. Mennar of Daath 1 X Naturel 5 ☐ Pending 2 ☐ Accidant invastigetion | 28e. Dete of Injur (Month, De) | Yaer) 28 | b. Tima of Injury | 28c. Inju Wo M 1 | ury et ork?]Yas 2 □ No | 28d. Describe | how injury occi | urrad | | |
| DIVIS | or Atte | Certification: | 3 ☐ Suicida 6 ☐ Could not be detarmined | 28e. Place of Injubuilding, etc | ury - At homa (Specify) | , farm, str | aat, factory, office | | 28f. Location City or To | (Straat and Num own, Stete) | ber or Rurai | l Routa Number, | |
| | To the Hospital or Attendi within 24 hours efter death To the Funerel Director: A completely filled in by the fi | edical C | 29a. Certifier 1 Certifying Ph (Check only one) | yalclan: To the best on niner: On the basis of end mennar sta | axamination | ige, deeth and/or inv | occurred et the transfer occurred et transfer occ | time, date end pleca, oplnion, daath occur | , and dua to the red at tha time | a causa(s) and r | nennar as sto e, end dua to | eted. the causa(s) | |
| | o the | Me | 29b. Signatura and titla of certifiar | 10 | | | 29c. Licen | nsa number | | 29d. Data sign | ned (Month, L | Day, Year) | - |
| | ->-0 | | 7-16 | the | m. | D | D | 17033 | | l | t-4- | 99 | |
| | 1 | | 30. Name and address of person of Edward H. | tombet reausa of de | eath (Itam 23: | a) (Type, | Print) 01 Pine | Bluff Rd | . Suite | 25 5 | alisbu | ry Wd. | |
| | Sta Registr | | 31. Dete filed (Month Day, Year) | 700 | ar's Signatura | 19 | Space | nsa number 19033 Bluff Rd | | | | U | |
| | | | | | | _ | | | | | | | |



99-2183-037

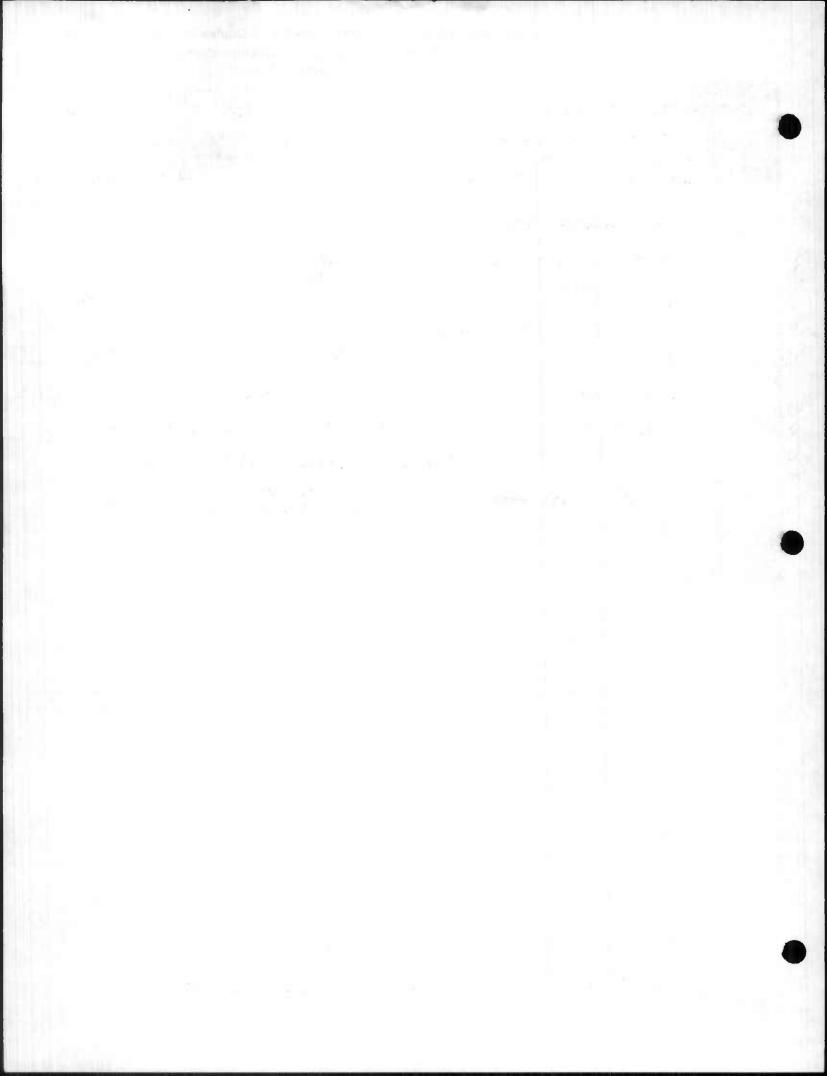
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| MARK TROWBRIDGE | | | | ate of Death | | Reg. No. | 131.52 | |
|---|--|--|--|---|---|-----------------------------|---|---------------|
| Physician /Medical | 1. Decedent's Nama (First, Middle, Last) MARK | ALAN | TROWBRI | DGE, SR. | 2. Dete of De Month APRIL | 14, 199 | | |
| Examiner | 4a Facility Name (If not institution, give s 27316 BOSSE ROAD | treet end number) | | 4b. City, Town, of MECHANIC | SVILLE | 4c. County of ST . MARY | | |
| Funeral Director | 5. Social Security Number 6. Sex 577–88–6615 | M 2□ F 7. Age (in yrs | (last birthday) If Un Month | der 1 Yeer If Under 24 H ns Days Hours Mi | | ,1959 W | 9. Birthplace (State or Fore Country) ashington, D | eign) . C |
| anyland del | 10a. Stete 10b. County | | ity, Town or Location | 4 | | | 10d. Inside City Lim | |
| O ifter death with the Mar r Name 23a or 28a-f a diner must be notified Funeral Director | Maryland St. Mary' 10e. Street and Number 27316 Bosse Drive | | Mechanics 101. | ville Zip Code 20659 | | 10g. Citizen of Wh | 1 ☐ Yes 2√☐ | NO |
| 15-0020 72 hours effect death with the Maryland *natural*, or flams 23s or 28=f show redical_Examinar must be notifiged at effect by Funeral Director | 11. Marital Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Evar in I Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas: | If Yas, s | cedent of Hispanic Origin? pecify Cuban, Mexican, Pur 2 No Specify: | (Specify Yas or No arto Rican, etc.) | Black, | American Indian, White, etc. | |
| within ene. | 15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) | cation completed) College (1-4or 5+) | 16a. Decedent's U (Give kind of life. DO NOT | work done during most of w Fuse retired) | rorking | D. C. Fi | iness/Industry | |
| yiand 2 suld be filed Mentel Hygi arked other aftic event, 5 | 17. Father's Neme (First, Middle, Last) | owbridge | | | ame (First, Middle, | | | |
| Mar nd 2 sho lith and 27 is m | 19a. Informant's Name/Reletionship (Type Mary E. Trowbridge) | oe, Print) | 19b. Mailing Addre | ess (Street and Number or 763, Chaptic | Rural Route Number | er, City or Town, Sand 2062 | | |
| S T T T T T T T T T T T T T T T T T T T | 20e. Method of Disposition 1 (3) Burial 2 Cremation 3 R. 4 Donetion 5 Other (Specify) | emovel from Stete | Plece of Disposition (Incemetery, cremetery) | or other piece) | Date // _ 1 0 _ 1 0 0 | | csville, MD | |
| Baltimo | 21. Signature of Funeral Service Visense | | The H | end Addrass of Facility untt Funeral Box 156, Wald | Home, In | С. | 0604 | |
| deeth certificate be executed with the set of for use as the bunal-transit and sicilan/Medical Examiner | Cause (Disease or Injury that initiated events resulting in death) Last | Due to (| INTOXICATION (or as a consequence of or as a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or es a consequence of or establishments. | ort): | . 1 | | | |
| P.O. BOX 6i et the deeth certific f by the attending petached for use as Physician/Mec | Part II. Other significant conditions con- | ributing to death but not re | sulting in the underlyin | g cause given in Pert I. | 23b. Did | tobacco use cont | il ribute to the cause of dea | eth? |
| P.O. het the detache | | | | g dated grown with one | | | 3 Probably 4 Unkn | |
| aw requires as been sign 2 should be | | | 44 | | | an autopsy med? | 24b. Were autopsy tinding available prior to completion of cause of death? | |
| = F # a 0 | | | | | | Yes 2□No | 1 Yes 2□ No | |
| - × 50 | 25. Wes case referred to medical examiner? **Comparison of the comparison of the co | ospital: 1 Inpatient 2 | ☐ ER/Outpatient 3☐ | Other | Home 5 A Residual | | (Specify) | |
| SION O tending Ph leath. for: After th the funeral cation: | 27. Menner of Daath 1 Netural 5 Pending 2 Accident Investigation | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. tnjury et Work? 1 ☐ Yes 2 ☑ No | | how injury occurre | | |
| 2 4 2 5 5 E | 2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At the building, etc. (Special HOME | nome, farm, street, fec | 1 | 28f. Location (: City or To | vn, State) | ror Rural Route Number, CHANICSVILLE MD | |
| To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert | 29a. Certifier 1 Certifying Physic 2 Medical Examin | cian: To the best of my kner: On the basis of examinand menner stated. | owledge, death occurre ation and/or investigati | ed et the time, date and pla ion, in my opinion, deeth oc | ce, end due to the | cause(s) and man | ner as stated. | |
| To the vithin To the comple | 29b. Signature and title of certifier | and member stated. | | 29c. License number | | 29d. Date signed | (Month, Day, Year) | |
| | Marinte | Means | | O.C.M.E. | 2 | APRIL 15, | 1999 | |
| | 30. Nama and eddress of person who cor | npleted cause of death (Ite | | Penn Street | , Baltimo | ore, Mary | land 21201 | |
| State Registrar | 31. Data tiled (Month, Dey, Year) APR 2 0 19 | 32. Registrer's Sign | <i>M</i> . | loca Kil | | | | |



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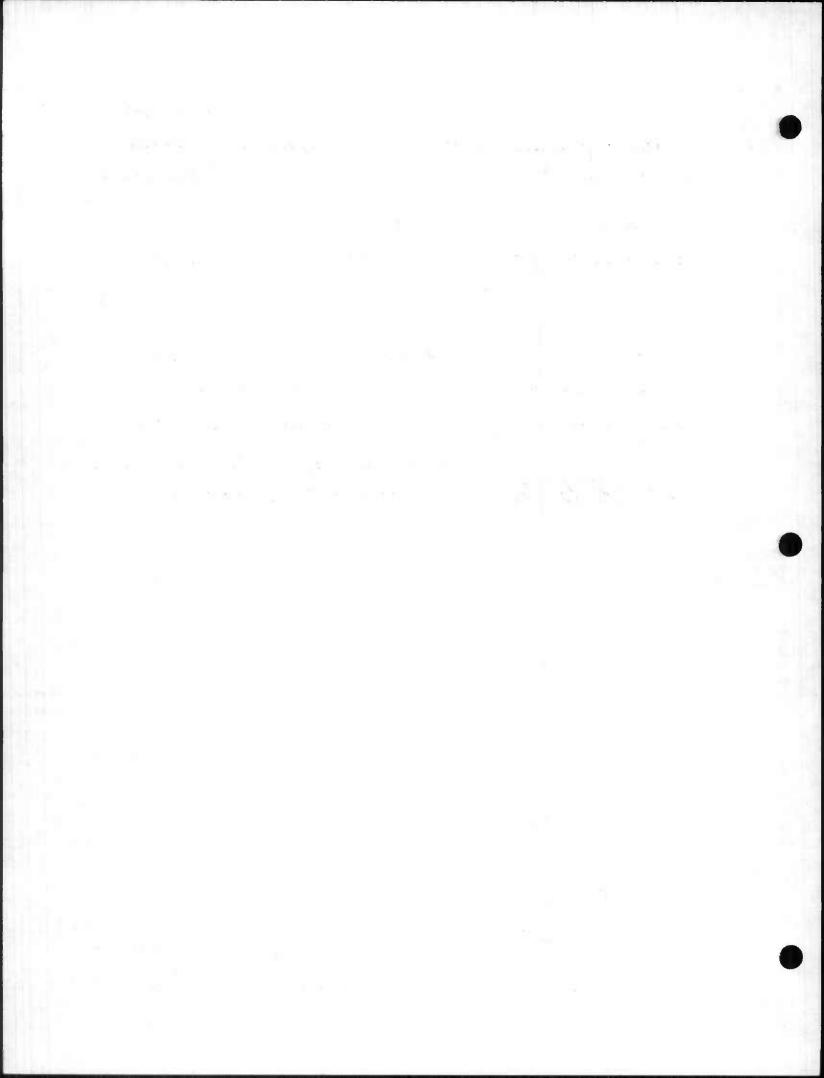
| | | Decedent'e Nama (First, Middle, Last |) | Cei | rtificate of | Death | | Reg. No. | å | 3. Time of Dea |
|--|----------------|---|---|--------------------------------|--|---|---------------------------------|------------------------------|------------|---------------------------------------|
| Physic | ian | | | | | | 2. Deta of Dea | Day | Yeer | |
| /Medi | | IRENE BURNS WELC | | | | | | 1999 | | 8:10 PN |
| Examir | ner | 4a. Fecility Neme (If not institution, giva | | | | 4b. City, Town, or | Location of Daeth | 4c. County | of Death | |
| | _ | Civista Medical | Center | | | LaPlata | | Char1 | es | |
| Funerai | | Social Security Number 6. Security Number | | yrs. lest birthday) | If Undar 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Dete of Birti (Month, Day | h Veerl | 9. Birthp | ieca (Stata or Fo |
| Director | | 268-16-9410 | ^{3M} 2√2 F 81 | Yrs. | Wionins Days | Hours Will. | FEB 8 | 1918 | Indi | |
| , | | Usual Rasidanca of Decedant | | | | | | | TIMI | alla |
| M W | | 10a. Stata 10b. County | 100 | : City, Town or Lo | ocation | | | | 1 | 0d. Insida City L |
| 1 3 | to | Maryland Prince Ge | eorge's (| Clinton | | | | | | 1- Yes 2 |
| 28 | Director | 10e. Street end Number | corde b | o I I I I O O I I | 10f. Zip Coda | | | 10g. Citizen of W | /hat Coun | itry? |
| 25 | 0 | | | | | 505 | | | | |
| al', or items 23a or 28a-f show Examiner must be notified at | Funeral | 6506 Clinton Mano | r Drive 12. Wes Decedant Evar | in 116 12 | | 735 | | 14 Page | USA | |
| 1 N | L. | | Armed Forcas? | in 0,5. | If Yes, specify Cub | tispanic Origin? (S en, Maxican, Puart | o Rican, etc.) | Bleck | k, Whita, | an Indian, etc. |
| natural', or items 23a or 28a-f show dical Examiner must be notified at | | 1 Navar Married 2 Married | 1 ☐ Yas 2 ☐ No If Yas, Giva X | | 1 □ Yas 21√2 No | Specify: | | Specify: | W | nite |
| 'natural', | d by | 3℃ Widowed 4 Divorced | Yaar or Dates: | | Λ. | | | | *** | 1100 |
| jiene. r than "natur ine Medical | Completed | 15. Decedant's Edu (Specify only highast grad | cation a complated) | (Giva | dant's Usual Occup | during most of wor | rkina | 16b. Kind of Bu | sinass/ind | dustry |
| - 20 | du | Elementery/Secondary (0-12) | Collage (1-4or 5+) | life. | DO NOT usa ratire | d) | | | | |
| P P | Ö | 12 | | C | ontrolle | r | | US Gove | rnmer | nt |
| d other | Be | 17. Fether's Nema (First, Middle, Last) | | | | | ne (First, Middla, | Maidan Sumam | a) | |
| 200 | ToB | Coorce Duran | | | | 1/ | Dagger | | | |
| th and Mer 7 is marke traumatic | - | George Burns 19a. Informant's Name/Ralationship (Ty | rpe. Print) | 19h Mallin | no Addrass (Street | and Number or Ru | Burns | r City or Town | State 7in | Code) |
| tre tre | | | | | | | | | | 0000) |
| Heelth Rem 27 other tr | | George I. Welch 20a. Mathod of Disposition | (son) | 6506 | Clinton_ | Manor Dr | | | | |
| | | · · · · · · · · · · · · · · · · · · · | amoval from State | camatary, crar | sition (Nama of matory or other pla | ce) | Data | 20c. Location - | City or 10 | wn, Stata |
| int: | | 1 ☐ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | | Metropol | itan Cre | matory 4- | -12-99 | Alexandr | cia. | VA |
| Department of Important: If It any Injury or once. | | 21. Signature of Fundal Service License | 80 | | 2. Nama and Addre | | | | | |
| Depart Import any inj snce. | | b (108.14 Fe | M0017 | 3 J | .H. Eber | wein Mort | tuary | | | |
| - | | 23a Pag/ Entar tha diséasa, or compliance, or heart feilura. List only or | and the same of the same of the same | 4 | 433 Whit | e Pls. La | a. White | P1s., N | 1D-20 | Approximata |
| g physician and es the bunel-transit | Examiner | Sequentially list conditions. | Due | Neem | puence of): | | | | - | |
| an ar niel-t | | Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaase or Injury | | | eces resources | | | | | |
| /sicie | edical | that initiated evants | Due 1 | o (or as a conseq | unnes off: | | | | | |
| D O | 8 | rasulting In daath) Last | | . (0. 00 0 00.004 | 50.00 | | | | | |
| John | 2 | | i | | | | | | | |
| attending for use | cia | | | | | | 1 | | | |
| by the stached | Physician/M | Part II. Other significant conditions con | tributing to death but not | rasulting In tha u | ndarlying cause gi | ven in Part I. | | obacco use con | tribute to | the cause of d |
| ed by deta | | | | | | | 101 | /es 2□ No | 3 Prot | bably 4 ☑ Uni |
| 5 8 | by | | | | | 1100 | - | | | |
| peen s | Completed | | | | | | 24e. Wes a perfor | n autopsy med? | ava | ere eutopsy findi allabla prior to |
| S CA | ple | | | | | | | | | nplation of cause death? |
| ate ha | ОШ | | | | | | 1 🗆 Y | as 2 No | 1 🗆 | Yes 2□ No |
| | 0 | 25. Was casa rafarrad to medical | | | | 26 Place of Day | ith (Check only or | | | |
| | OB | axaminar? | lospital: | o∏ 50/0 · · · · | Ott For Ott | ner: | | | | |
| ral di | H | 27. Menner of Death | 1 Inpatiant 28a. Data of Injury | 2 ER/Outpatien 28b. Tima of | I SLI DOA | 4 Li Nursing H | oma 5 Rasid | | | /) |
| Afte | ion | Naturel 5 ☐ Panding | (Month, Day Yea | r) Injury | Wo | | _00. D000100 11 | arrangery occurre | | |
| s after death. is Director: After the ad in by the funera | Certification: | 2 Accidant Invastigation 3 Suicide 6 Could not be | | | | Yas 2 No | | | | |
| lin by | TT. | 4 ☐ Homicide determinad | 28a. Placa of Injury - / building, etc. (Sp | noma, tarm, str ecify) | aat, ractory, office | | 28f. Location (S City or Tow | treet and Numbe n, Stata) | er or Hura | i Houte Number, |
| within 24 hours after of To the Funeral Direct completely filled in by | | | | | | | | | | |
| 24 hours Funeral etely filled | cal | 29a. Cartifier 12 Certifying Phys | Icien: To the best of my | knowladga, death | occurred at tha ti | ma, date and place | , end dua to tha c | ausa(s) and mer | nner es st | eted. |
| n 24 he Fu | edical | one) 2 Medical Examin | ner: On tha basis of axan and mannar stated. | mation and/or inv | rastigetion, in my (| pinion, daath occu | rred at tha lima, c | rata and place, a | na aue to | una ceuse(s) |
| within 2 To the comple | Σ | 29b. Signatura and title of certifies | 20 | | 29c. Licans | a numbar | 2 | 9d. Date sygned | (Month, I | Day, Year) |
| | | \(\lambda \mathcal{A}\) | face | | D 000 | , | | 4/11 | 99 | |
| | - | 20. Name and address of | | Marine marine and | D-22 |)/4 | | 1/1// | 1. | |
| | - 1 | 30. Nama and address of person who co | | | Print) | | | | | |
| | | T T D 24 | | | | | | | | |
| | | Timothy T Pace, MD 31. Data filed (Month, Day, Year) | 12070 01d] 32. Registrar's S | Line Cen | ter Suit | e 202 W | aldorf, | MD 2060 | 2 | |



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | Certificate of Death | ı | Reg. No. | 13454 |
|--|--|----------------------|--|--|---|---|--|
| | Dhusis | t | Decedent's Neme (First, Middle, Last) | | 2. Dete of Dee | oth Dey Yee | 3. Time of Deeth |
| | Physici /Medi | | Leroy F. Welsh | | April | 8 1999 | 8:00 PM |
| | Exami | | 4e. Fecility Nema (If not institution, give street end number) | 4b. City, Town, or | Location of Death | 4c. County of De | eth |
| | | | Golden Ase Guest Home | Sykes | ville | Carroll | County |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last | birthdey) If Under 1 Yeer If Under 24 Hrs Months Days Hours Min | | | Birthplece (State or Foreign Country) |
| - | Director | | 220-34-7419 1M 2□F 87 Usual Rasidence of Decedent | Yrs. World's Day's Flour's Will | 2-13- | 1912 Ma | aryland |
| Vardan | f show | or | | own or Location | | | 10d. Inside City Limits 1 ☐ Yas 2√☐ No |
| the | 28a | Director | Maryland Carroll Mour | nt Airy 10f. Zip Code | | 10g. Citizen of Whet | Country? |
| × C | 0 8 | ō | | | | | · · |
| eeth | 8 2 | era | 5825 Cabbage Spring Rd. 11. Marital Status 12. Was Decedent Ever in U.S. | 21771 | Specify Vec or No- | United St | narican Indian. |
| Within 72 hours efter deeth with the Mandand | ital thgiene. Id other than "natural", or liems 23s or 28s-f ehow event, the Medical Examinat must be neithed st | Completed by Funeral | 1 Never Merried 2 Merried 1 Yes 2 No if Yas, Give Year or Detes: | 13. Wes Decedent of Hispanic Origin? (\$\forall f \text{ Yes, specify Cuban, Maxican, Puants)}\$ 1 ☐ Yes 2 ☑ No Specify: | to Rican, etc.) | Black, Wi | hite, etc. |
| 72 h | netro Speak | tec | 15. Decedent's Education (Specify only highest grade completed) | 6e. Decedent's Usual Occupation | orkina | 16b. Kind of Busines | ss/Industry |
| within | e a | nple | Elementery/Secondery (0-12) College (1-4or 5+) | (Give kind of work done during most of wo life. DO NOT use retired) | , King | | |
| illed wi | giene. | Con | - 1 | Farmer | | Agricultu | ire |
| nd 2 should be file | and Mental Hygie ia markad other t raumatic event, tr | Be | 17. Father's Neme (First, Middle, Last) | 18. Mother's Na | me (First, Middle, | Melden Sumema) | |
| D D | Mental arkad o atic eve | 10 | Charles Oliver Welsh | Lucy Vi | rginia O | wings | |
| should | if of Heelth and Mer if Item 27 is merks or other traumatic | | 19e. Intorment'e Neme/Reletionship (Type, Print) | 9b. Melling Address (Street end Number or R | Turel Route Numbe | r, City or Town, State | , Zip Code) |
| nd 2 | Heeith and 27 learn tra | | Charlotte L. Twenty (Daughter) | 3860 Hooper Rd. New W | indsor. | MD 21776 | |
| oemit. Peges 1 er | Depertment of Heeith Important: If Item 27 any injury or other th pnce. | | 20a Method of Disposition 20h Place | of Disposition (Name of | Dete | 20c. Location - City | or Town, Stete |
| 909 | int: If its | | X burier 2 Dictariation 3 Directional from State | atary, crematory or other place) | / /12/00 | | 100 |
| - E | ndur njur | | 21. Signature of Funoral Service Licenses | 22. Nama end Addrass of Fecility | 4/12/99 | Mount Airy | , MD |
| | Department important: If any injury or once. | | 2. Symbol of College C | Burrier-Queen Fun | eral Dir | ectors, P. | Α. |
| | | | and should | 1212 West Old Lib | erty Rd. | Winfield, | |
| | nysician | | 23a. Pert1. Enter the disaase, or complications that caused the deeth. D shock, or heert tellure. List only one cause on each line. | o not enter the mode of dying, such as cardle | oc or respiretory an | rest. | Approximate Intervel Between Onsat end Deeth |
| | Medicai xaminer | | Immediate Cause (Finel disaasa or condition | aller Accident | | | >luh |
| - L. | Adminier | | resulting in deeta) | e consequence ot): | | | |
| Ö | ** | Examiner | Peray D | beciefty Secretar | | | 2 (41 |
| executed | and -tran | carr | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | a consequence of): | | | / |
| 9 9 | urial | Û | cause. Enter Underlying Cause (Disease or Injury | | | | 1 |
| rtificate be ex | g physician end es the burial-transit | Aedicai | that latieted execute | a consequence of): | | | |
| 100 | | | | | | | |
| eth cer | ettendir for use | an | d | | | | |
| 9 | e ette | sici | Part ii. Other significant conditions contributing to death but not resulting | g in the underlying cause given in Part I. | 23b. Did t | obacco use contribu | rte to the cause of death? |
| that the de | ed by the e | y Physician/ | | | 101 | /ee 217 No 3□ | Probably 4 Unknow |
| he lew requires that the | has been signed ge 2 should be del | Completed by | | | 24a. Wes a | | b. Were autopsy tindings avellable prior to completion of cause of death? |
| F | page page | 0 | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2 ☐ No |
| lician: T | s certificate he director, page | Be | 25. Wes case reterred to medical exeminer? | 26. Plece of De | eth (Check only or | ne) | |
| Physician: | this ce at direc | 2 | Hospital: | Outpetient 3 DOA Other: 4 Nursing I | Home 5 Rasid | ence 6 Other (S) | pecify) |
| ding Ph | | | 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation 28e. Dete of Injury (Month, Dey Year) | D. Tima of 28c. Injury et Work? M 1 Yes 2 No | 7 | ow Injury occurred | |
| al or Attending | 井井口 | Certification: | 3 Sulcide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, building, etc. (Specify) | | 28f. Location (S City or Tow | | Rural Route Number, |
| • Hospit | within 24 hours of To the Funeral D completely filled i | edical | 29e. Certifier (Check only Check only C | ge, deeth occurred et the time, date and place end/or investigation, in my opinion, deeth occ | e, and due to the durred et the time, o | ause(s) end menner lete end place, and d | as steted. ue to the ceuse(s) |
| oth | omp omb | Me | 29b. Signature and title of bertifies | 29c. License number | | 29d. Data signed/(Mo | nth, Day, Year) |
| - | S F 0 | | Valet to | D man | | 4/0/00 | |
|) | | | Jures /a | 22006 | | 711117 | |
| | | | 30. Name and address of person who-completed cause of death (Item 23a | 1425 Liberty, | Rd E | dersbu | g Nep 2178 |
| | Sta Registr | _ | 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture | h land | | / | |

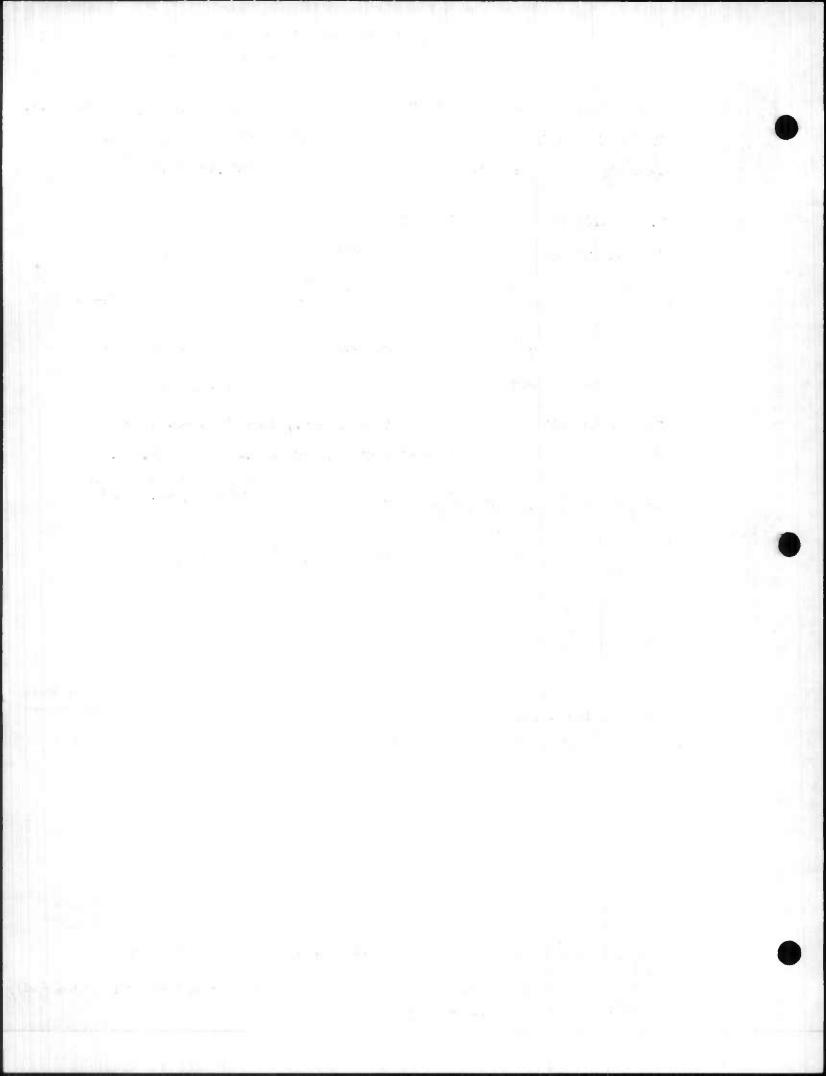


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State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

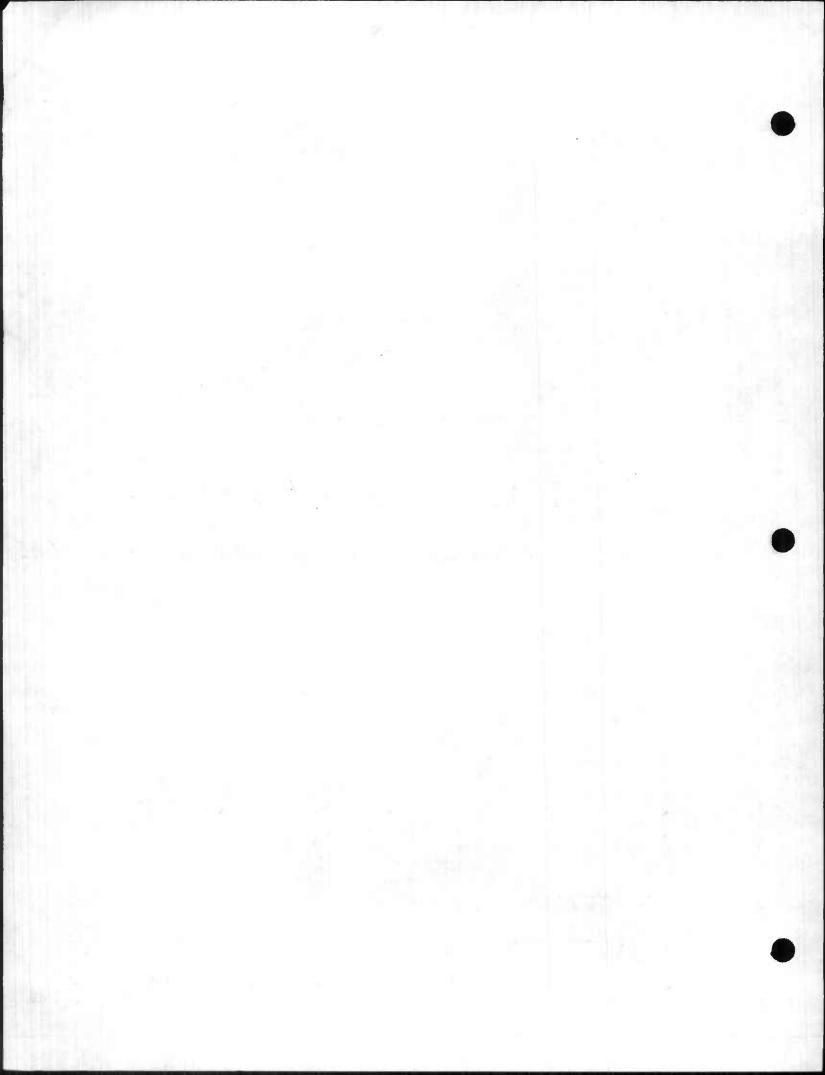
| | | | | | | Cer | tificate of | Death | | Reg. No. | - E | 9. 6 | C S: |
|---------------------|---|----------------|---|---|-------------------------------|-------------------------------|---|--|------------------------------------|------------------------------|--|---|----------------------------------|
| | Division in | | 1. Decedent's Neme (First, Midd | | | | | | 2. Date of De Month | | Yeer | | e of Death |
| | Physici /Medi | | ESTHE | R LOUISA W | INDER | WILL | IAMS | | MARCH | | 1999 | 3:4: | 5 P.M. |
| | Examir | | 4e. Facility Name (If not institutio | | | | | 4b. City, Town, or L | ocation of Death | 4c. Count | y of Death | | |
| | | | 1803 JERSEY | | | | W. 1 | SALISBU | | | OMICO | | |
| 37 | Funeral Director | | 5. Social Security Number 072-20-6708 Usual Residence of Dacedent | 6. Sex 7. Ag | ge (In yrs. le: | st birthdey) Yrs. | Months Days | | 8. Date of Bir | *, Y91910 | 9. Birthp Coun MD . | iace (Stet itry) | te or Foreign |
| | Mand Mand | | 10a. Stata 10b. County | / | 10c. City, | Town or Loc | cation | | | | 1 | Od. Inside | City Limits |
| | Man | tor | MD. WICOM | 1ICO | SALI | SBURY | | | | | | 1 □ Y | es 2XNo |
| | th with the 23a or 28 | al Director | 10e. Street and Number 1803 JERSEY | ROAD | | | 10f. Zip Code 21801 | | | 10g. Citizen of USA | What Coun | itry? | |
| Maryland 21215-0020 | ges 1 and 2 should be filed within 72 hours efter death with the Maryland to f Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examine | by Funeral | 11. Merital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced | if Yes Give | | | Vas Decadent of Yes, specify Cul ☐ Yes 2 No | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | | ce - Americ ick, White, by: AFRO | etc. | |
| 2-0 | 72 ho | eted | | nt's Education est grede completed) | | 16a. Decede | ent's Usuei Occu | upetion a during most of work | cina | 16b. Kind of B | usiness/Inc | dustry | |
| 121 | ithin | Completed | Elamantary/Secondary (0-12) | Collage (1-4or 9 | 5+) | | ONOT use retin | e during most of work ed) | 9 | HOUSEK | FEPIN | IC. | |
| 7 | lled w hygien her ti nt, th | | 17. Fether's Name (First, Middle, | | | DI | DIMESTIC | 18. Mother's Nam | n /Finnt thirdello | | | - | |
| ano | ad of ad of | Be c | | R WINDER | | | | 18. MOTHER'S INGILI | | | | | |
| 2 | 2 should end Men is marke surratic | 2 | 19a. Informant's Name/Relations | | | 19b. Mailine | n Address (Stree | et and Number or Rui | | A BROWN | | Code) | |
| | Heelth er Heelth er Hem 27 Is other trau | | EUGENIE SHIE | FLDS | | | | AVE., SAL | | | | | |
| Baltimore, | S S E P | | 20a. Method of Disposition 1 XBuriel 2 Cremation 4 Donetlon 5 Other (S | 3 ☐Removal from State | cer | nca of Dispos metery, crem | ition (Name of setory or other pla | eca) | Date | 20c. Location HEBRON, | - City or To | wn, State | |
| Balti | permit. Depertminents any Inju | | 21. Signature of Eynaral Service | Licansee | De. | | Name and Addr | ress of Fecility J | OLLEY M | | | | |
| | | | 23a. Pert1. Enfer the disease, or shock, or heart failure. List | r complications that all se | the deap | | | ring, such as cardiac | | | 1 | Approxim | nate |
| I | Physician /Medical Examiner | | Immediate Cause (Final disease or condition rasulting in death) | · A-te | ٥٠ ما | | | hourt | dis | ow | | Interval E Onset en | |
| | Jansit | Examiner | | b | | | | | | | | | |
| ,09 | be axec | | Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaasa or Injury | с | Due 10 (01 a | as a consequ | Jenice Orj. | | | | | | |
| x 68760, | eath certificate be axecuted attanding physician and i for use as the burial-transit | Medical | that initiated events resulting in death) Last | L | Due to (or a | as a consequ | ence of): | | | | 1 | | |
| Bo | attan for u | clan | | | | | | | | | | | |
| P.O. | as that the death ce igned by the attand be detached for us | y Physician/ | Part II. Other significant condition | ons contributing to death b | ut not result | ting in the un | derlying cause g | iven in Part I. | | tobacco uae co Yes 2□No | | | e of death? Unknown |
| Records, | been s | Completed by | choire or | truel. | Som | ~ ((| afr | | 24a. Was | en autopsy ormed? | ave | ere autops ailable prid mpletion of daeth? | sy findings or to of cause |
| | | 20m | | | | | | | 10 | Yes 2 No | 10 | Yes 2 | 2□ No |
| Vita | ysicism: The law is certificata has director, page 2 | Be | 25. Was case raferred to medica examiner? | | | | | 28. Place of Deal | th (Check only o | one) | | | |
| 5 | Physic this or | ၉ | 1 Yes 2 No | Hospital: 1 Inpatie | | R/Outpatient | 3LI DON | | ome 5/2 Resi | | | Y) | |
| U C | Iling P | on | 27. Manner of Death 1 ☑ Natural 5 ☐ Pendir | | y Year) 2 | 28b. Time of Injury | 28c. inju W | uryat ork? □Yes 2□No | 28d. Describe | how Injury occu | rred | | |
| Division of | i or Attending Physician: after death. Director: After this certific in by the funeral director, | Certification: | 2 Accident Investi 3 Suicide 6 Could 4 Homicida determ | not be nined 28a. Placa of Inj building, at | jury - At hom c. (Specify) | ne, farm, stre | | | 28f. Location (City or To | Street and Num wn, Stata) | ber or Rura | il Route N | lumber, |
| | To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After thi completaly filled in by the funeral | edicai Ce | 29a. Certifler 1 Certifylr (Check only one) Medical | ng Physician: To the best Examiner: On the basis of and manner st | f examination | ledge, death on and/or inv | occurred at the tastigation, in my | time, date and placa, opinion, death occur | and due to the red at the time, | causa(s) and m | annar as si , and dua to | lated. | ea(s) |
| | omple | Me | 29b. Signature and titla of confilling | or | | | 29c. Licer | nse number | | 29d. Date sign | ed (Month, | Dey, Year | r) |
| | ->-0 | | > > () () | en | | | 1279 | -114 | | ulel | 00 | | |
| | | | 30. Name and address of person | who completel cause of d | leath (Item 2 | 23a) (Type, F | | | | () | | | |
| | Sta | ite | 31. Date filed (mails Dey, Yeer) | che 32. Rygistr | ar's Signatu | ıra , | 2 | June J | 4, 1 | ali vb. | Ny | 4 | 4 218 |

State Registrar



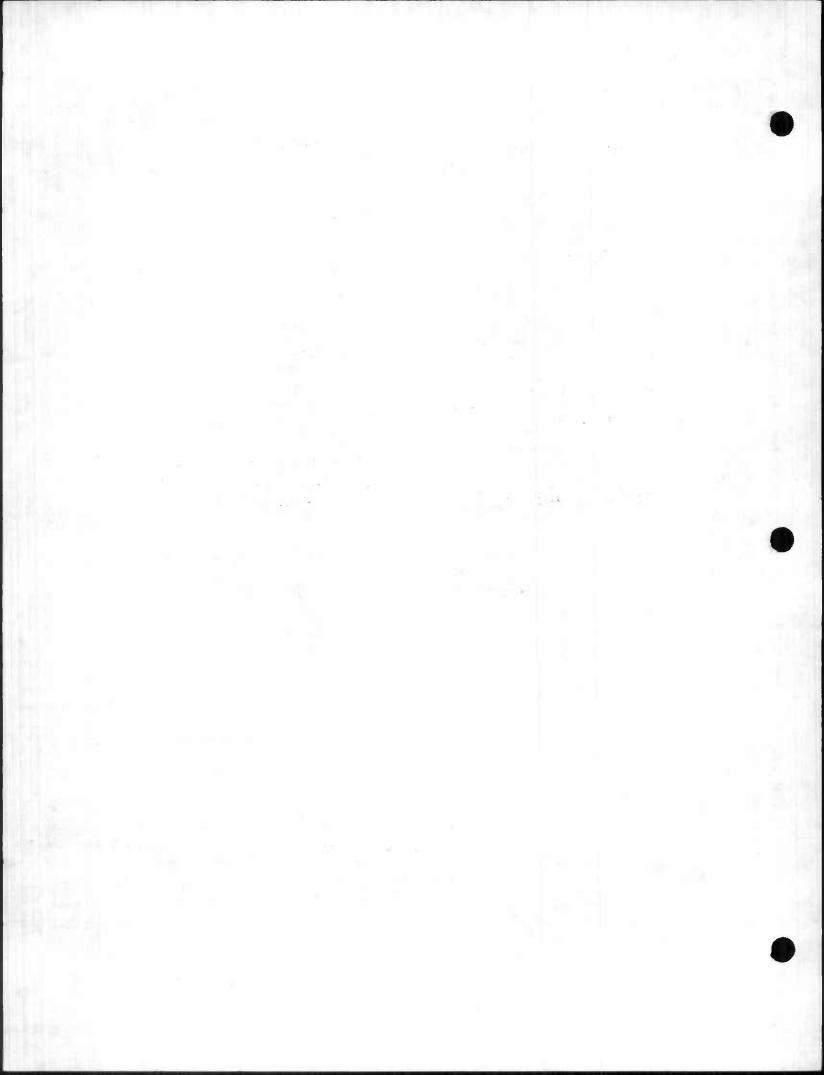
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| 1. Decedent's Nama (First, Middle | e [act] | | Cer | rtificate of | Deam | 1 | 2. Data of E | Reg. No. | | | 3. Tima of Death |
|--|---|--|--|--|--|------------------------|--|---|--|--|--|
| | ANONE | WISE | | | 4b. City, Tow | А | Month | 11, 19 | 999 County of | rear | 10:20 AM |
| 1403 HARWICH C | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | - () | WALDO | | | | HARL | | |
| 5. Social Security Number 577 – 38 – 3605 | 6. Sex 1 □ M 2ÅJ¥F | 7. Age (tn yrs | : last birthday) Yrs. | If Under 1 Yaar Months Days | | Min. | 8. Data of E (Month, I | Birth Day, Year) | 9 | | ce (State or Foreign S K a |
| Usual Rasidence of Decedent 10a. State 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | 10d | . Inside City Limits |
| Virginia Warre | n | | Strasbu | ra | | | | | | | 1 ☐ Yas 2 ☒ No |
| 10a. Street and Number | | | 01 40 54 | 10f. Zip Code | | | | | | at Country | 7 |
| RRT 1, Box 21 | | | | | 657 | | | | USA | | |
| 11. Marital Status 1 □ Nevar Married 2 □ Marr 3 ○ Widowed 4 □ Divorced | Armed | | | Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No | | in? (Spec Puerto Ri | ify Yes or I ican, atc.) | | | American Whita, etc Whita | |
| 15. Decedent (Specify only highes | | d) | (Give | dent's Usual Occu kind of work done | during most | of working | a | 16b. Kind | d of Busi | iness/Indus | stry |
| Elementary/Secondary (0-12) | | (1-4or 5+) | life. L | DO NOT use retin Treasure | id) | | | Floo | thic | 21 C | ontractor |
| 17. Father's Name (First, Middle, | Last) | | | rreasure | | 's Nama (| (First, Midd | lle, Maiden S | | | UIICT ac cut |
| Clarence Emil | Anderson | n | | | Wy | llima | a Rut | h Knap | р | | |
| 19a. Informant's Name/Ralations | | | | ng Address (Stree | | | | | | | ode) |
| Stefan I. Kocz | erzuk- Fi | | | Harwich | Circle | e, Wa | | 7 | | | Challe |
| 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | | m State | cemetery, cren | sition (Name of matory or other pla | | 1 | Date | | | ity or Towr | |
| 4 Donation 5 Other (S) 21. Signature of Fuheral Service | 4 | | | T CREMAT | | | | | WAL | DORF. | , MD |
| 101-14 | pury | | | Nama and Addr E HUNTT | | | | | | | |
| John P. Kni 23a. Part1. Enter the disease, or | | 1164 | P. (| 0.BOX 15 | C 11011 | | MAADA | ZLAND | 206 | 0/ | |
| Immediate Causa (Final diseasa or condition resulting in deeth) | | TERIO | ith. Do not ente | ar the mode of dy | ing, such es c | ardiec or | respiretory | arrest, | 206 | Airo | pproximate itarval Between inset and Death |
| Immediate Causa (Final diseasa or condition | | Due to (| sch. Do not ente | ar the mode of dy | ing, such es c | ardiec or | respiretory | arrest, | | Airo | itarval Between |
| Immediate Causa (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events | | Due to (| SCAR (or es a conseq | ar the mode of dy | ing, such es c | ardiec or | respiretory | arrest, | | Airo | itarval Between |
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| Immediate Causa (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Pert II. Other significant conditions. | a. AR. b c d Hospital: 1E | Due to (Due to (Due to (death but not received) | ith. Do not enti- SCEAG (or es a consequence as a consequ | ar the mode of dy DTC (juence of): juence of): juence of): uence of): inderlying causa g | ven in Part I. | of Deeth on | 23b. Di 11 24a. W. pe | d tobacco u Yee 2 as an autops rformed? Yas 250 Yore) Of dau sidence 6 | Donard Control | Air In In In In In In In In In In In In In | ne cause of death? |
| Immediate Causa (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Pert II. Other algnificant conditions awaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pendin Investig Suicide 6 Could or Suicide 6 Could or Suicide Suici | b c d Hospital: 1 | Due to (Due to (Due to (Due to (death but not receive the control of th | cor as a consequence or as | ar the mode of dy DTC (juence of): juence of): uence of): uence of): uence of): anderlying causa g anderlying causa g anderlying causa g | ven in Part I. 26. Place of her: 4 Numiny at the years 2 Numiny | of Deeth (sing Home) | 23b. Di 1[24a. Wipe 1C(Check onl) a 5 Kaa 3d. Describ | d tobacco u Yee 2 as an autops rformed? Yas 259 y one) of day sidence s e how injury | Document | ribute to the same of decision | ne cause of death? Later and Death Lat |
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| Immediate Causa (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Pert II. Other significant condition 25. Wes casa rafarred to medical axaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could rate investig 4 Homicida 29a. Certifiar 1 Certifyting | d. Hospital: 1 Eggiation not be 28e. Place building Physician: To the Examiner: On the | Due to (Due to | sulting in the understand the second | ar the mode of dy DTCC (juence of): juence of): juence of): u | ven in Part I. 26. Place her: 4 \(\text{Num} \) Num invest (Yas 2 \(\text{Num} \) N | of Deeth sing Home | 23b. Di 10 24a. Wipe 15 (Check only a 5 Kas 3d. Describ | d tobacco u Yee 2 as an autops fromed? Yas 259 y one) Of dau sidence 6 e how injury a (Street and own, State) | ee control No 3 y Other occurred | A In In In In In In In In In In In In In | itarval Between inset and Death Cause of death? It will be be be be be be be be be be be be be |
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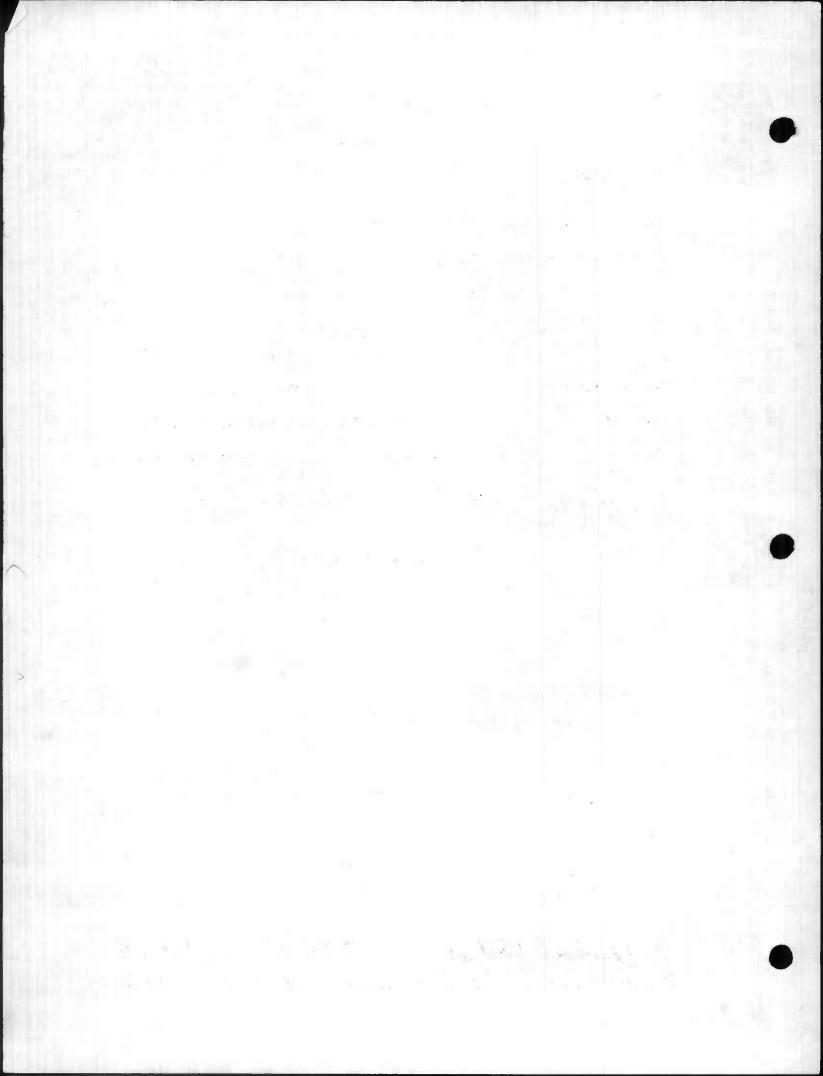
| oris | Adelle | e Ziemski | State of Maryla | | cate of | | | neg. No. 9 9 | 15 | 71.57 |
|--|--|---|---|---|-------------------------------|---|------------------------------------|---------------------------|-------------------------|--|
| F | Physician /Medical | 1. Decedent's Neme (First, Middle, L | lelle Z | | () | | 2. Date of Dea Month | Day 08. 1999 | Year | 3. Time of Death |
| F | Examiner uneral rector | | k Drive | | Jnder 1 Year | | 8. Date of Birti | Car) | 9. Birthpli | ace (State or Foreign |
| D | | 218-48-2495 Usuel Residence of Decedent 10a. State 10b. County | 10c. 0 | City, Town or Location | 0 | | Feb 20 | 1997 / | | Od. Inside City Limits |
| e Maryl | be noursed Director | Maryland Carro | .11 | HAMP. | | 2 | | | | 1 ☐ Yes 2 ☑ No |
| with th | 3a or 2 or De or | | Creek Rd | 10 | Y. Zip Code | 074 | | 10g. Citizen of WI | | ry? |
| 5-0020 72 hours after death with the Maryland | instural", or items 23a or 28a-f show dieal Examiner must be notified at etect by Funeral Director | 11. Meritel Stetus 1 Never Married 2 Merried | 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: | If Yes | | Hispanic Origin? (Sp an, Mexican, Puerto | pecify Yes or No- Rican, etc.) | | - America , White, e | |
| within within ane. | mp idm | 15. Decedent's Elamentery/Secondery (0-12) | ducation | 16a. Decedent's (Give kind life. DO N | of work done OT use retire | during most of work ad) | king | 16b. Kind of Bus | iness/Ind | lustry |
| Po di pi | arked other attc avent, II | 17. Fether's Neme (First, Middla, Las | ") | ///erci | RAPIO | 18. Mother's Nam | | |) | |
| Maryla 12 should | = = | 19e. Informant's Name/Ralationship | (Type, Print) Former | | 1 | t and Number or Ru | ral Route Numbe | r, City or Town, S | Stata, Zip | Code) |
| Fe and Heat | 40 | Lean J. 2 iemsk 20a. Method of Disposition 1 | Removal from State | Place of Disposition cemetery, cremator | y or other pla | 109) | Date Uliz 199 | 20c. Location - C | | wn, State |
| Baltimo permit. Page Department of | Important: any injury once. | 21. Signifure of Funerel Service Lice | | Pritt | ne and Address | ess of Facility ral Home | + Chap | el, P.A. | | |
| S8760, icate be executed W | attending physician and to the set the burial-transit and the set the burial-transit and the set that the set | Immediate Cause (Finel disease or confidence of heart failure. List only limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last | blunt by | | nd constant | | | | | Approximate Interval Between Onset and Death |
| D. O. Hre death | d by the attending stached for use a physician/M | Pert II. Other significant conditions | contributing to death but not re | sulting in the underly | ying cause gi | iven in Pert I. | 23b. Did 1 | obacco use conf | tribute to | the cause of death? |
| S, P. | signed by the a d be detached t d by Physic | | | | | | 101 | res 25 No | 3 Prob | ebty 4 Unknown |
| ecor law requ | 2 shoul | | | | - | 2.5 | 24a. Wes perio | an autopsy med? | con | ore autopsy findings hilable prior to impletion of cause death? |
| - F | certificate he rector, page Be Com | 25. Wes casa raferrad to medical | | | | 00 81 | 198 | | 167 | PYes 2□ No |
| | 8 O | examiner? | Hospitel: 1 Inpatient 2 | ☐ ER/Outpatient 3 | DOA Ot | 26. Place of Dea her: 4 Nursing H | | lence 6 □Othe | r (Specify | <i>'</i>) |
| Division or Attending ifter death. | Nector: After the funeral in by the funeral ertification: | 27. Menner of Deeth 1 Netural 2 Accidant 3 Suicide 4 Homicida 5 Pending investigatic determined | 28a. Placa of Injury - At building, atc. (Spec | 22.04 N | | nyat ork?]Yes 2G⊱No | SWill 28f. Location (S City or Tow | treet and Numbe | ed o | and beaken I Route Number, |
| To the Hospital within 24 hours | To the Funeral Dir completely filled in Medical Cert | 29a. Certifier 1 Certifying P | hysician: To the best of my kn miner: On tha basis of examin and menner stated. | owledge, death occi | | | end due to tha | ause(s) and man | | |
| Toth | To the | 29b. Signeture end title of certifier | 961 | | 29c. Licen: | se number | | 29d. Date signed April 10 | | |
| | | 30. Name and address of person who | completed causa of death (the | | | treet, Bai | | | | |
| F | State Registrar | 31. Date filed (Month, Dey, Year) APR 1 2 19 | 32. Registrar's Sign | g. | Spark | N | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 45 Am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) Examiner 1-10 tak in 4105 000 If Under 24 Hrs. 8. Dete of Birth (Month, Dey, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. **Funeral** Deys Months 1□M 2₩F 39 Yrs. 14,1959 220-74-9809 Jul MD Director Usuel Residence of Decedent 10a, State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1) Yas 2 □ No Director MD N/A BALTO 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code Examiner must be r 3319 Echodale Ave APT Funeral 21214 U.S.A.

14. Rece - American Indian,
Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced the Medical E Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filled within Elementary/Secondary (0-12) College (1-4or 5+) Medica1 N/A Nursing Assistant marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) and Mental George Armstead OVDA HOWARD 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Pages 1 and 2 Larhonda Lomax Item 27 i 4106 Erdman Ave Balto, Md 21213 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition Department of Important: If its any injury or o ti 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete King Mem Pk 4-27-99 Balto, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility BETTS FUNERAL HOME 21. Signeture of Funerel Servica Licensee 1129 N. Caroline St Balto, Md 21213 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Examiner Examine end transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physicien e Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the a Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Cytomegalovino Colitis þ 24b. Were autopsy findings evelleble prior to completion of cause of death? should 24e. Wes an autopsy performed? Completed certificate has blirector, page 2 s 1 ☐ Yes ale No 1 Yes 2 No director, 25. Wes cese referred to messal exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name end address of person who completed ceus of death (Item 23a) (Type, Print) ST. Baltimore, Mi 2/201 Kent. 100(N. Cothedral D 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State APR 26 1999 Registrar

BHH



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 4/ston pri 01:53 A 27 ROGEY /Medical 4h) City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Daltimore John topkins HOS 8. Dete of Birth (Month, Dey, Year) June 21,1956 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 15 M 2□ F 42 219-62-2846 Yrs Director MD Usuai Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location man be notified at MD N/A 1 Yas 2 No BALTO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3015 Kentucky Ave 21213 Apt 1 U.S.A Herns 23s Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? f\U\dagge\rangle\ran 14. Race - American Indien, 11. Marital Status Bleck, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after neal of Health and Mentel Hygiene.
ntt: If Item 27 Is marked other than "natural, or its nry or other thaumalts event, its Marial Earn is nry or other thaumalts event, its Marial Earn is Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamentary/Secondery (0-12) Coilege (1-4or 5+) 12th N/A Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Roger Alston Pearl Branch 19e. Informent's Neme/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Pearl Alston 3015 Kentucky Ave BaLTO, Md 21213 20b. Ptece of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Cem 1 Surial 2 Gremation 3 Removel from State Department of important: If any injury or pace. 4 Donetion 5 Other (Specify) Garrison ForestVA 4-27-99 Owings MIlls, MD 22. Name end Address of Facility Funeral Service Licen Betts Funeral HOme 1129 N. Caroline St. Balto, 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finei day disease or condition resulting in deeth) Examiner Examiner a day physicien and the burief-transit the death certificate be executed Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Bowe hem ic Box 68760 Smal days Physician/Medical Due to (or es e consequence of): esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? i certificata hes t director, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: Be 25. Wes case raferred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edicai Certification: To this 27, Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Neturel n 24 hours after death.

Ne Funeral Director: After Selective filled in by the fun 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified RES -000 MD 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

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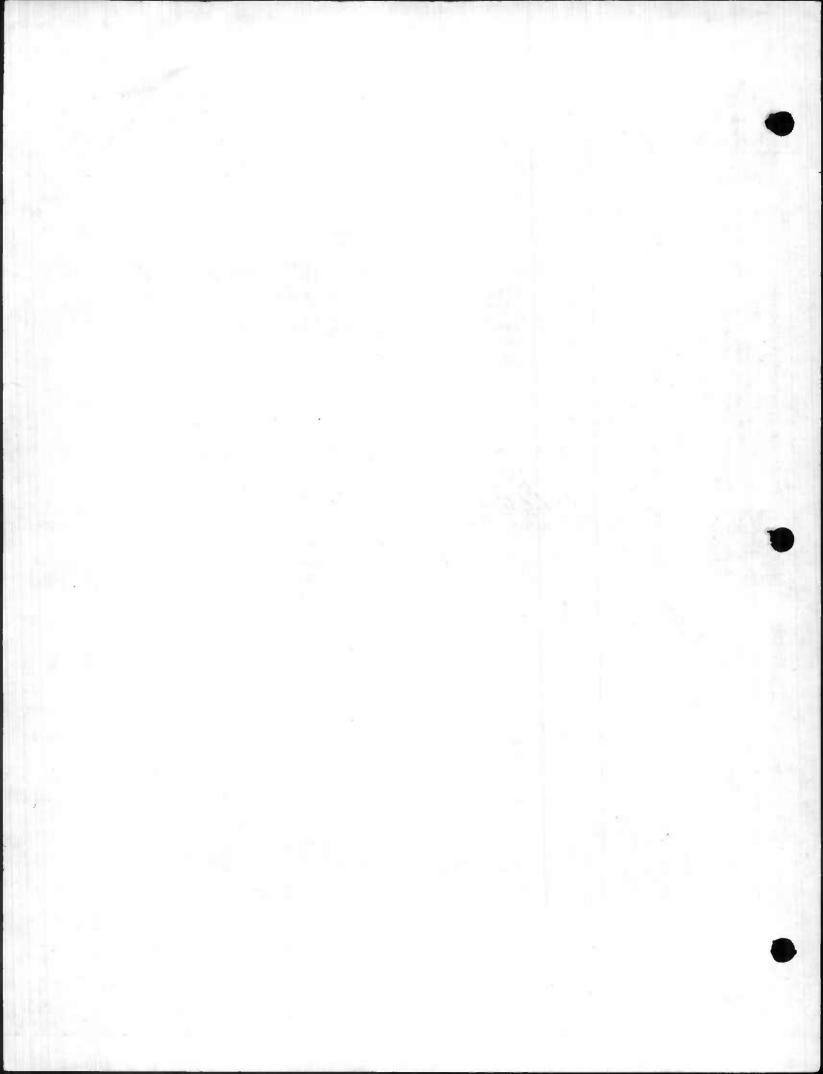
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32. Registrer's Signeture

Baltimorp

MD

21287-9106



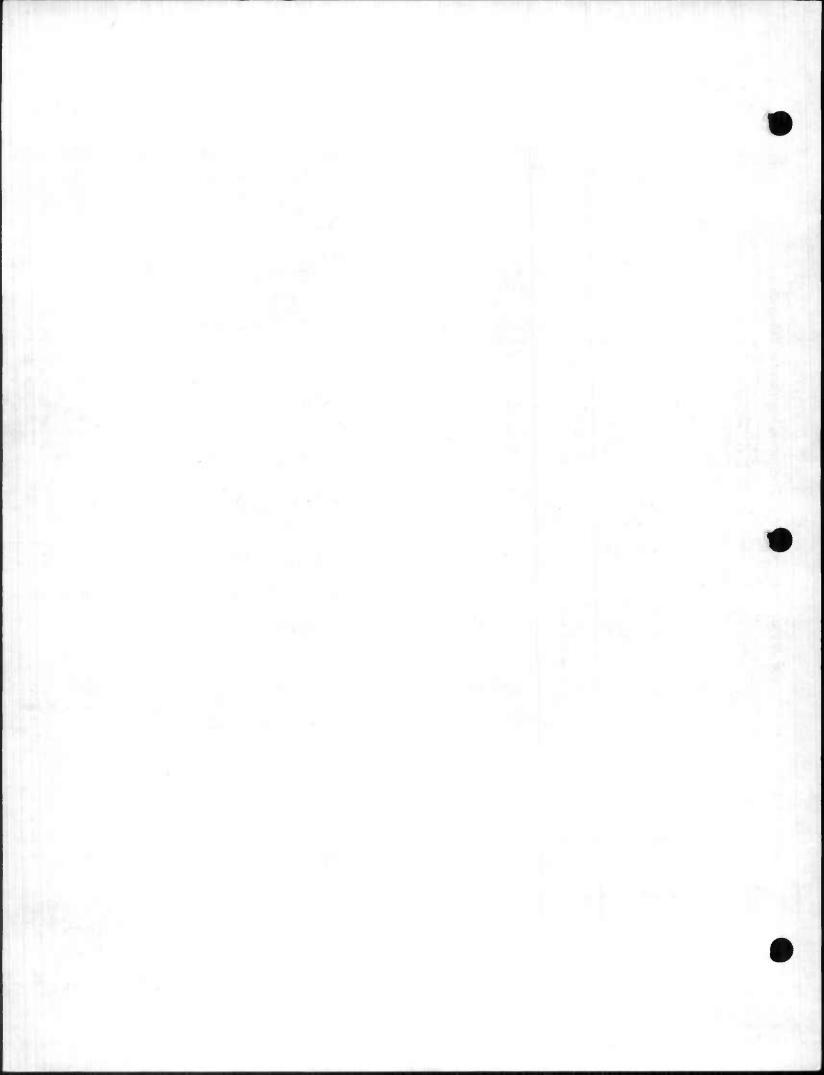
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State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death | R | og. No 9 9 | 3460 |
|--------------------|--|---------------------------------------|-------------------------|--|
| | 1. Decedent's Neme (First, Middle, Last) | 2. Dete of Deet Month | h Dey Yeer | 3. Tima of Death |
| ysician Medical | Ross P. Avera | | 21, 1999 | 7:05 P.M |
| aminer | 4a Fecility Name (If not Institution, give street end number) 4b. City, Town | n, or Location of Death | 4c. County of De | ath |
| | 4304 Forest View Avenue Baltim | more City | I | n/a |
| al | 5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Months Deys Hours | Hrs. 8. Dete of Birth (Month, Day, | Year) 9. Bi | irthplace (State or Foreign Country) |
| r | 057-03-5906 | 3/23/03 | Mis | ssissippi |
| | Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. insida City Limits |
| ŏ | MD n/a Baltimore City | | | N☐ Yas 2☐ No |
| Director | 106. Street and Number 10f. Zip Code | | 0g. Citizen of Whet C | Country? |
| ត់ | | | | ountry r |
| - | 4304 Forest View Avenue 21206 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin | n? (Specify Yes or No- | USA 14. Bace - Am | nerican Indian, |
| | Armed Forces? If Yes, specify Cuben, Mexican, I 1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No | Puarto Rican, atc.) | Black, Wh | |
| | 3 ☐ Widowed 4 ☐ Divorced if Yes, Give Year or Dates: | | Specify: | White |
| | 15. Decedent's Education 16a. Decedent's Usual Occupation | | 16b. Kind of Businas | s/industry |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | of working | | |
| | 4 Years School Teacher | - 10.00 | Educat: | ion |
| | 17. Father's Nema (First, Middle, Last) 18. Mother's | s Neme (First, Middle, I | Maiden Sumeme) | |
| 1 | WILLIAM AVERA CAF | RRIE SHOEMA | CHER | |
| | 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number | or Rural Route Number | City or Town, State, | Zip Code) |
| | Agnes Avera Wife 4304 Forest View Av | venue Balt | imore, MD | 21206 |
| | 20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Ramoval from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) | Dete | 20c. Location - City of | r Town, Steta |
| | 4 Donation 5 Other (Specify) GARRISON FOREST VET. C | EM. 4/26/99 | OWINGS M | ILLS, MD |
| | 21. Signature of Funeral Service Econsee 22. Nama and Address of Fecility | | | |
| | OFOL Facts Page | | | Home, P.A. |
| | 8521 Loch Rav 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as calebook of heart failure. List only one cause on each line. | | | Approximete |
| 4 | shock, or heart failure. List only one cause on each line. | | | Interval Between Onset end Deeth |
| | Immediate Cause (Final disease or condition Acute Pulmonary Ea | lanca | | scuts |
| | resulting in death) Due to (or as a consequence of): | CKOU C | • | 11 |
| | Coxective Heart Fa | ilure | | Sept. 98 |
| | Sequentially list conditions, Due to (or as a consequence of): | | | 11 |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Signature Cause) | 0112 | | Jept 98 |
| | that initiated events resulting in death) Last Due to (or es a consequence of): | | | - |
| Medical | | | | |
| Dy Physicians | d | | | i |
| | Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. | 23b. Did to | bacco use contribu | te to the cause of death? |
| | Semilita | 1 🗆 Y | 00 200 NO 30 | Probably 4 Unknown |
| | - Comment of the comm | | / | |
| To the second | | 24a. Was e perion | | . Were autopsy findings available prior to |
| | | | H. T. | complation of cause of death? |
| | | 1 🗆 Yı | as XONO | 1 ☐ Yes 2 ☐ No |
| | 25. Was case referred to medical examiner? | of Death (Check only on | (e) | |
| | Hospital: | ing Home 5 Reside | enca 6 Other (Sp | pecify) |
| | 27. Manner of Death 12 Netural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work? 28c. Injury at Work? | 28d. Describe ho | ow injury occurred | |
| 1 | 2 Accident investigation M 1 Yes 2 No | 0 | | |
| | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (St City or Town | | Rural Route Number, |
| Certification: | | | | |
| 80 | 29a. Certifor Contifor Check and Check and Contifor Check and C | place, end due to the co | ause(s) and manner | as stated. |
| edical | and menner steted. | | | |
| Σ | 290. Signature and file of confirer | 2 | 9d. Date signed (Mo | nth, Day, Year) |
| | co my forgen, and. Dogog | 9 | 4/22 | 199 |
| | 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) | 1-311 | 01 | |
| | M. GONGON M.J. 8/14 Sandsiper Circ | le Salto | · led. 2 | 21236 |
| te | 31. Date filed (Month, Day, Year) 32. Registrar's Signeture | 7 | | |
| rar | APR 2 6 1999 | | | |

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day Year **Physician** Mabel В. Allen April 1:39 AM 23 1999 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 7499 Monte Video Ct. Jessup Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yaar 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 □ M 2 X F Months Days Yrs. 296-18-8423 74 Director July 11 1924 MD Usual Residence of Decedent the Maryland 10a Stata 10b County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot trsumstic event, the Medical Examines must be notified at 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 800 Old North Point Rd 21224 USA of filed within 72 hours after death all Hygiene.
I other than "naturel", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Reca - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Own Home Housewife permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any Injury or other treumatic event, page. 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) George Krepps Martha Campbell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Cresta /daughter 800 Old North Point Rd Baltimore, MD 21224 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 26 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1999 Oak Lawn Cemetery Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Part1. Enter the diserver, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Metastatic breast cancer 8 years Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, edical Dua to (or as a consequanca of) 88 ian/Me signed by the at Physic Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yae 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to complation of ceusa of death? Completed 24a. Was an autopsy peen has le 2 page 1 Yas 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: director 25. Was case referred to medical Be 26. Piece of Death (Check only one) Daughter Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) P 1 Yes 2 No this Home funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Netural 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by th 3 Suicida 28f. Location (Streat end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature and little of certifier Interne D37013

State Registrar

Bruce M. Conger, M.D.

31. Date filed (Month, Dey, Year)

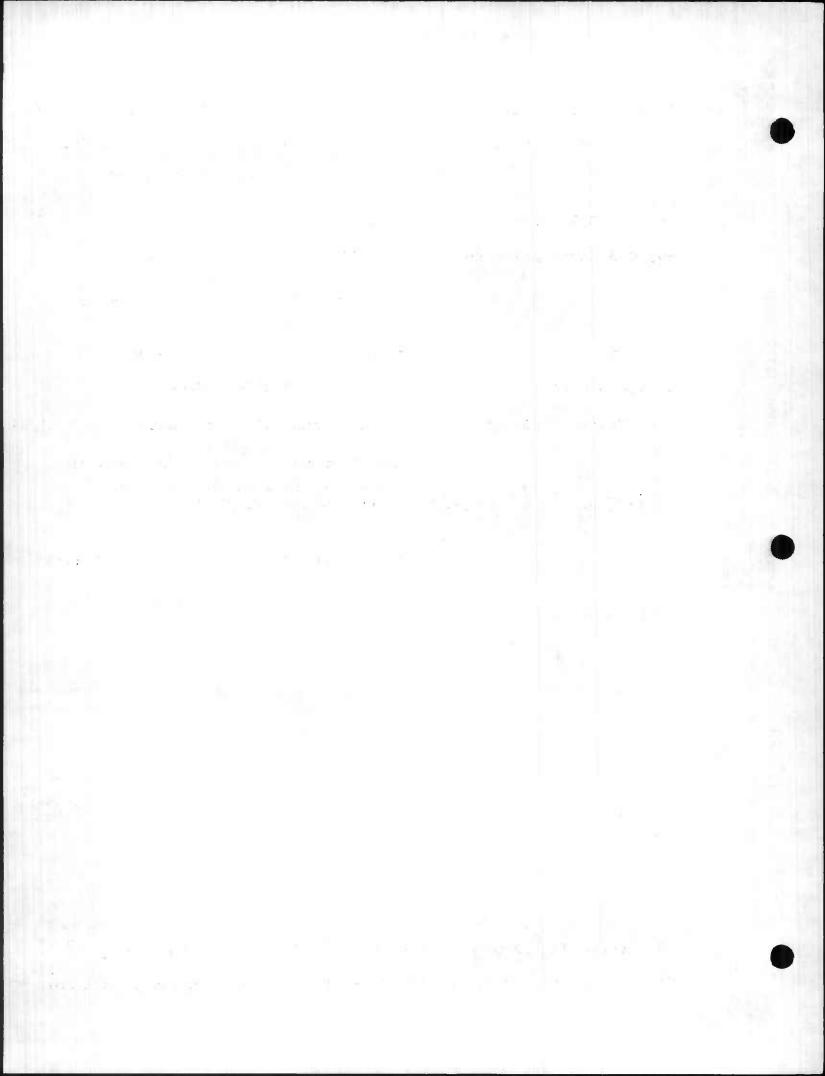
32. Registr

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

M.D. # 210 11055 Little Petuxent Pkwy.
32. Registrar's Signature

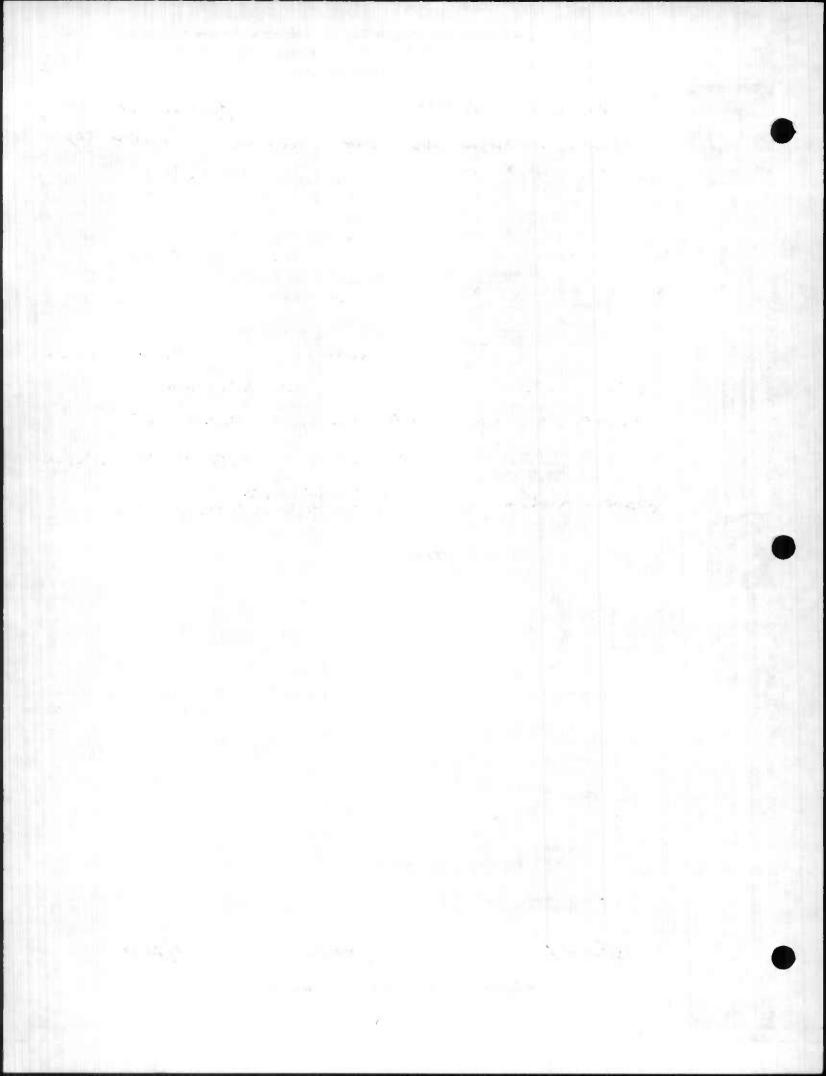
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| | 20a. Mathod | | | 7- | | 20b. Place of cematar | Disposition (f | Vama of or other pla | ce) | | Date | 20c. Location | - City or To | own, Stete |
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gladys R. Anthony 6:15 A.M. 23 1999 April /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Anne Arundel Millersville If Under 1 Year | If Under 24 Hrs. | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 20, 1902 1 M 2 X F 96 212 26 3574 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 U.S. 340 Stiemly Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: þ White 3⊠ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th 17. Faiher's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth (not available) Charles E. Willett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angie McGuire 216 Kuethe Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from State 4/26/99 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. ramerouski 4001 Ritchie Highway Baltimore, Md. 21225 by condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, plat only one cause on each line. Approximete tntervel Between Onset end Death MYOLANDIAC INFANCTION Immediale Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NFECTION- DRINMY TRACT. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were eutopsy findings evailable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2DNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3927 ANNAPOLIS KOND 21227. 4SHOKK CHATTERTEG

State Registrar

Funeral

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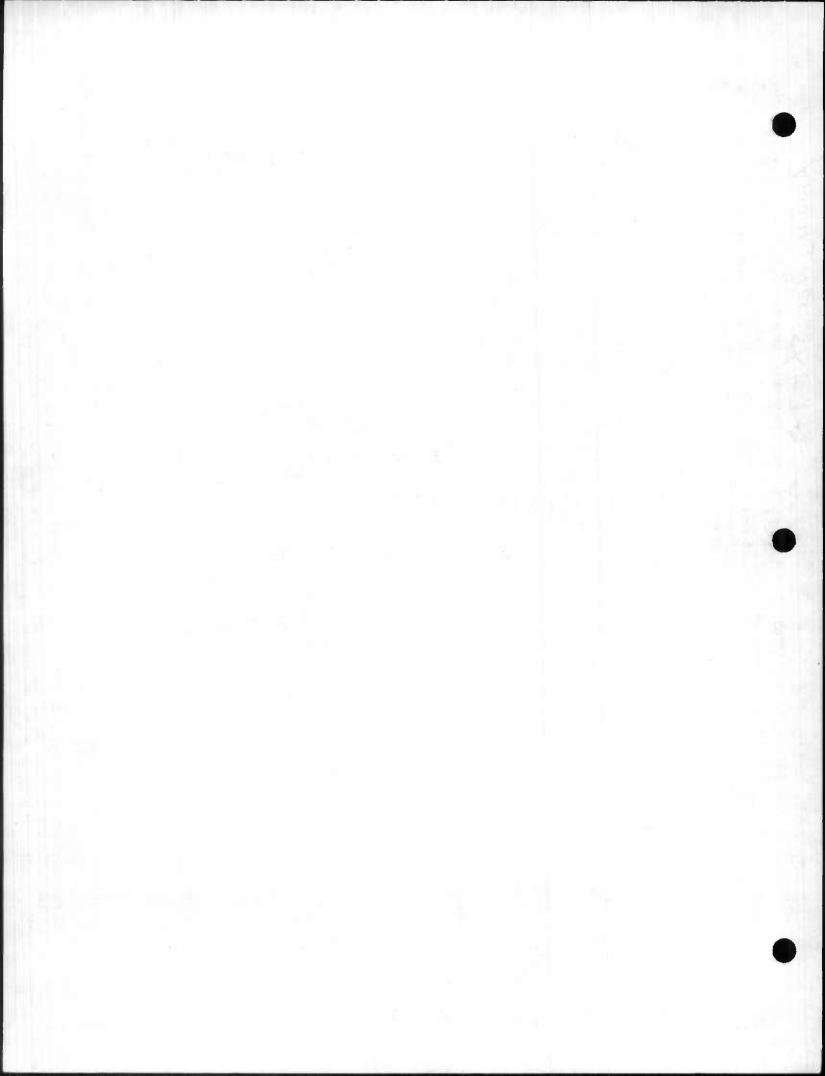
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31. Date filed (Month, Day, Year) APR 2 6 1999

32. Registrar's Signature



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Baltimore, Maryland 21215-0020

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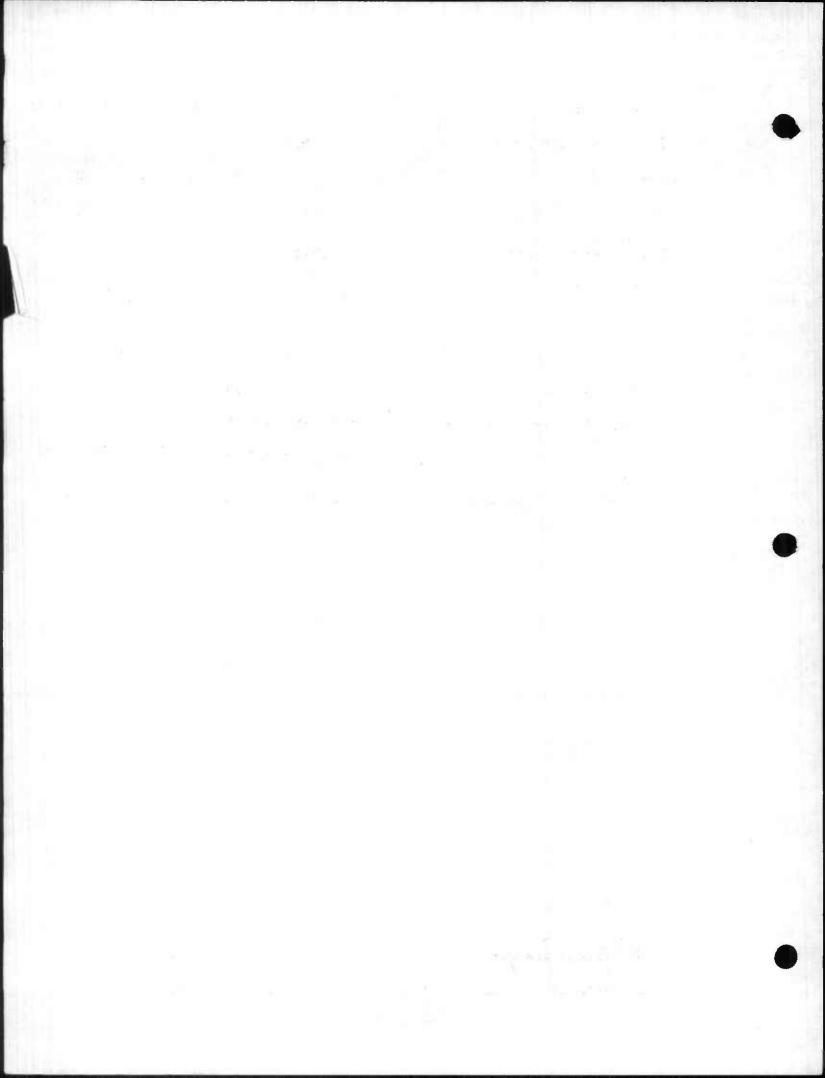
Medical/Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, data and place, and dua to the ceuse(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number

30. Nama and addrass of person to completed cause of daath (Itam 23a) (Type, Print)

9600 North Point Road, Fort howard, MD MD 21052

Arastoo Yazdahi 31. Data filed (Month, Day, Yaar) APR 26 1999 32. Radistrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dale of Deeth 3. Time of Deeth April 22, 1999ª Mervin William Blouse, Sr. 8:57 A.M. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 3006 Rogers Avenue Ellicott City Howard County M Under 1 Year If Under 24 Hrs. Hours Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months 1 X M 2 □ F AUG. 4, 70 220-22-5218 1928 Pennsylvania Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Howard Ellicott City 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3006 Rogers Avenue 21043 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Korean 14. Race - American Indien, Bleck, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) General Maintenance State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Robert Willis Blouse Mary Ellen Mathews 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Phyllis Davis (daughter) 3006 Rogers Avenue, Ellicott City, Maryland, 21043 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery Apr. 24 Woodlawn, Maryland 22. Name and Address of Fecility. Loring Byers Funeral Directors, Inc. 21. Signeture of Funeral Service Licensee 8728 Liberty Rd. Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause en each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Finel minutes diseese or condition resulting in death) ronary Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No Heart Failure 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? obstructive Pulmonary Disesse 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 8 □Other (Specify) 1☐ Yes 2☐ No 27 Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 5 Pending Investigation 1 (XNaturel 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

The lew requires that the death certificate be assected Box 68760, P.0. Division of Vital Records, Physician: this After or Attanding To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Af

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic avant, the Medical Examples must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.

Int: If Nam 27 Is marked other than "natural", or Ne.

Ity or other traumatic avant, the Medical Estaturals.

Department of Important: If any Injury or once.

Physician /Medical

Examiner

Completed by Physician/Medical Examiner

Medical Certification: To Be

29a. Certifier (Check only one)

29b. Signeture end little of certifier

-hesley

uneral

the

filled in by

21215-0020

Saitimore, Maryland

Funeral Directo

þ

Completed

Registrar

State

Yellott MD W

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

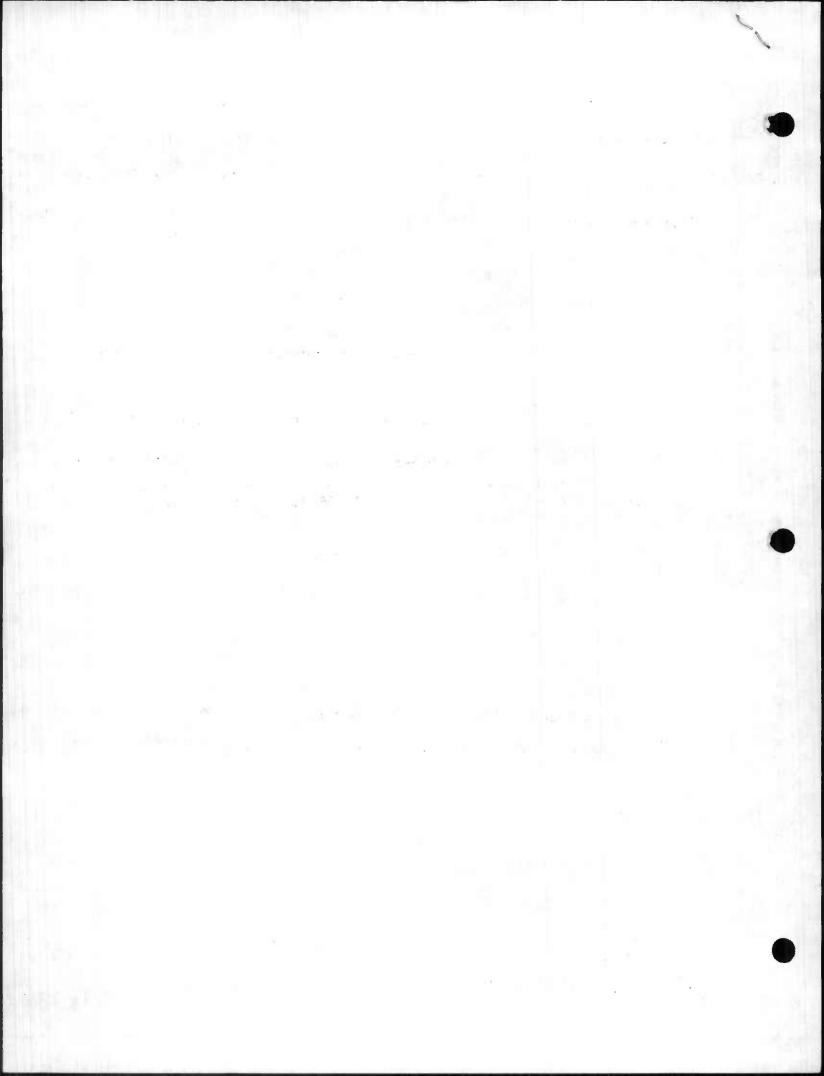
29d. Dete signed (Month, Dey, Year)

Pike, Ellicott CIty md 21043

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

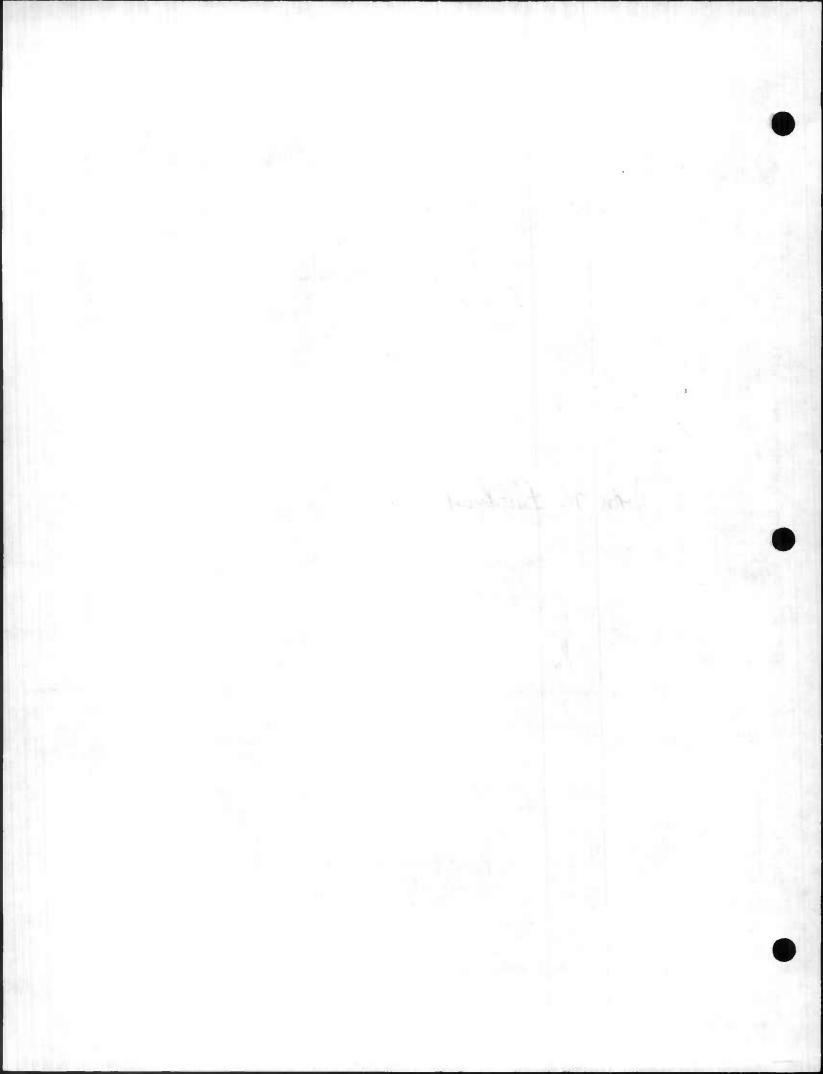
8492 more National 32. Registrar's Signeture

31. Dete filed (Month, Day, Year) APR 2 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

| an I | Deceded News (First Middle | - [4] | Cei | rtificate of | Death | | Reg. No. 99 | 131 | me of Death |
|------|--|---|---|--|--|---|---|--|--|
| | . Decedent's Name (First, Middle Leroy | George | Bri | ght | | 2. Dete of De April | 23, Day 1999 | Year | 4.5 Am |
| I. | e Facility Neme (If not institution) 40 Middleboro | | | | 4b. City, Town, or L Baltimore | | 4c. County of Baltin | | |
| 5. | Social Security Number 216–28–2623 | | (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | | 8. Date of Bir (Month, Da May 19 | , 1931 | 9. Birthplace (Country) Marylan | State or Foreign |
| 1 | Isuel Residence of Decedent Oe. State 10b. County Iaryland Balti | more | Oc. City, Town or Lo Baltimore | | | | | | side City Limits Yes 2 No |
| 10 | 0e. Sfreet and Number | ugh Road | | 10f. Zip Code 2122 | 1 | | 10g. Citizen of W | | J 100 E # 110 |
| | 1. Merital Status 1 Never Merried 2 Marr 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? ited Yes 2 No | er in U,S. 13. \\10/10/48 \\/ \/10/70/ | Wes Decedent of fixes, specify Cut | Hispanic Origin? (Sp ean, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | - 14. Race Black Specify: | - American Ind , White, etc. White | |
| | 15. Decedent (Specify only highes Elementary/Secondery (0-12) | t's Education | 16a. Deced (Give life. L | dent's Usual Occu kind of work done DO NOT use retire dities E | during most of work ad) | sing | 16b. Kind of Bus | | ent |
| 1 | 7. Father's Neme (First, Middle, | Last) | Contain | arcies i | 18. Mother's Nem | | | | |
| | Russell Brigh 19e. Informent's Neme/Reletions | | 19b. Mailin | ng Address (Stree | Alice H | ral Route Numb | er, City or Town, S | State, Zip Code |) |
| _ | Geraldine E. Br | ight (wife) | | | rough Road | | | | |
| 20 | 0e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3 Removel from Stete | | netory or other pla | | Date / O.O. | 20c. Location - (| | |
| 2 | 4 Donetion 5 Dother (S) 21. Signeture of Funeral Service | | Holly Hil | Name and Addr | ess of Facility | | Baltimor | e, mary | /Iailu |
| | Inter 9 | Burkow | ste 14 | Bruzdzins | ski Funera Zastern Av | n Home, Tenue. E | P.A. Ssex. Ma | ryland | 21221 |
| d | mmediate Cause (Finel disease or condition esulting in deeth) Sequentielly list conditions, I any, leeding to immediate ause. Enter Underlying Jeuse (Disease or injury heat initiated events | Du | ue to (or es a conseque to (or es e conseq | juence of): | Ancen | | | 7 Ma | NT K |
| re | esulting in death) Lest | d | e to (or es a conseq | uenca of): | | | | 1 | |
| | | | | | | | | | |
| P | ert II. Other significant conditio | ns contributing to death but i | not resulting in the ur | nderlying cause g | iven in Pert I. | 23b. Did | tobacco uss con | tribute to the c | ause of death? |
| P | ert II. Other eignificant conditio | ens contributing to death but I | not resulting in the ur | nderlying cause g | iven in Pert I. | | | | ause of death? |
| P | ert II. Other eignificant condition | ns contributing to death but | not resulting in the u | nderlying cause g | iven in Pert I. | 1 🗆 | | 3 Probably 24b. Were au available | 4 Unknow |
| | | | not resulting in the ur | nderlying cause g | | 1 □ | an eutopsy med? | 3 Probably 24b. Were au available completi of death | 4 Unknow |
| 2: | 5. Wes case referred to medical exeminer? 1 □ Yes 250No 7. Menner of Death | Hospitel: 1 ☐ Inpatient 28e. Dete of Injury | 2 ☐ ER/Outpatien | nt 3□ DOA O | 26. Place of Dee ther: 4□ Nursing He | 24a. Wes perfect the (Check only come 5 🗷 Resident) | an eutopsy med? | 3 Probably 24b. Were au available completi of death 1 Yes | 4 Unknown |
| 2: | 5. Wes case referred to medical exeminer? 1 □ Yes 2,52No | Hospitel: 1 Inpatient 28e. Dete of Injury (Month, Day Y | 2 ER/Outpatien 28b. Time of Injury - At home, ferm, str | nt 3 DOA O | 26. Place of Deether: 4 Nursing Heart of Natron (1988) 1988 2 No | 24a. Wes perfo | an eutopsy med? Yes 2 No one) dence 6 Othe how injury occurred. | 3 Probably 24b. Were au available completi of death' 1 Yes | 4 ☐ Unknown topsy findings prior to on of cause 2 ☐ No |
| 2: | 5. Wes case referred to medical exeminer? 1 | Hospitel: 1 Inpatient 28e. Dete of Injury (Month, Day Y pation 28e. Pleca of Injury building, etc. (g Physicien: To the best of ex | 2 ER/Outpatien 28b. Time of Injury - At home, ferm, str. (Specify) my knowledge, death carminetion and/or for | ot 3 DOA Of 28c. Inju | 26. Place of Dee ther:4 □ Nursing He iny at ork?] Yes _2 □ No | 24a. Wesperfo | an eutopsy wmed? Yes 2 XX0 One) dence 6 Othe how injury occurre Street and Number wn, State) | 3 Probably 24b. Were au available completi of death' 1 Yes r (Specify) ad | 4 Unknown topsy findings prior to on of cause 2 No |
| 2: | 5. Wes case referred to medical exeminer? 1 | Hospitel: 1 Inpatient 28e. Dete of Injury (Month, Day Y pation 28e. Pleca of Injury building, etc. (g Physicien: To the best of an examiner: On the basis of an and menner steles | 2 ER/Outpatien 28b. Time of Injury - At home, ferm, str. (Specify) my knowledge, death carminetion and/or for | nt 3 DOA Of 28c. Inju W. M 1 ceef, lactory, office | 26. Place of Dee ther:4 □ Nursing He iny at ork?] Yes _2 □ No | 24a. Wesperfo | an eutopsy wmed? Yes 2 No one) dence 6 Othe how injury occurre Street and Number wn, State) | 3 Probably 24b. Were au available completi of death' 1 Yes r (Specify) ad or or Rural Roundard Rou | 4 Unknown topsy findings prior to on of cause 2 No |
| 2: | 5. Wes case referred to medical exeminer? 1 | Hospitel: 1 Inpatient 28e. Dete of Injury (Month, Day Y spation 28e. Pleca of Injury building, etc. (g Physician: To the bast of ex and menner steted | 2 ER/Outpatien /ear) 28b. Time of Injury - At home, ferm, str. (Specify) my knowledge, death carminetion and/or find. | of 3 DOA Of 28c. Inju Wo 1 Coef, Jactory, office on occurred et the trestigation, in my 29c. Licen | 26. Place of Deether: 4 Nursing Heiry at pk? Yes 2 No | 24a. Wesperfo | an eutopsy ymed? Yes 2 ⊠No one) dence 6 □Othe how injury occurre Street and Number wn, State) cause(s) and mer date and place, a | 3 Probably 24b. Were au available completi of death' 1 Yes r (Specify) ad or or Rural Roundard Rou | 4 Unknown topsy findings prior to on of cause 2 No |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEMS #1 PER MD G770 4-26-99 WR. Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) CORA BRAWLEY 7:30 AM RAWL 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number)
Bon Secour Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 219-05-9587 7. Age (In yrs. lest birthdey) Birthplaca (Steta or Foraign Country) Months 1□ M 2□ F Yrs. Aug. 18, 1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1002 Cooks Lane 21229 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) College (1-4or 5+) Elementary/Secondary (0-12) 10 Mile House Restaurant Business 18. Mother's Name (First, Middla, Maldan Sumame) 17. Fether's Name (First, Middla, Last) Thomas Johnson Sally Cooper 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Star Route 202 A, Barrington, New Hampshire Bill Cooper, Son 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Baltimore Wash. Crematory 4/21/99 Laurel, Maryland 4 □ Donation 5 □ Other (Spacify) 22. Name and Address of Feeility Witzke Funeral Homes, Inc. 21. Signature of Funeral Servica Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 randa Lemmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate fnterval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Munknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Neturel 5 Pending

Examiner and I-transit the death certificate be executed physicien ar Division of Vital Records, P.O. Box 68760 attending pi for use es t signed by the a The law requires thet been si s certificate has b al or Attending Physicien: The safter death.

In Director: After this certificet and in by the funeral director, pages of the safter Be To the Hospital or within 24 hours aft To the Funeral DI completely filled in

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Examine

Physician/Medical

þ

Completed

Certification: To

Medical

Funeral

Director

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercises must be northed at pine.

Physician

/Medical

Baltimore, Maryland 21215-0020

1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

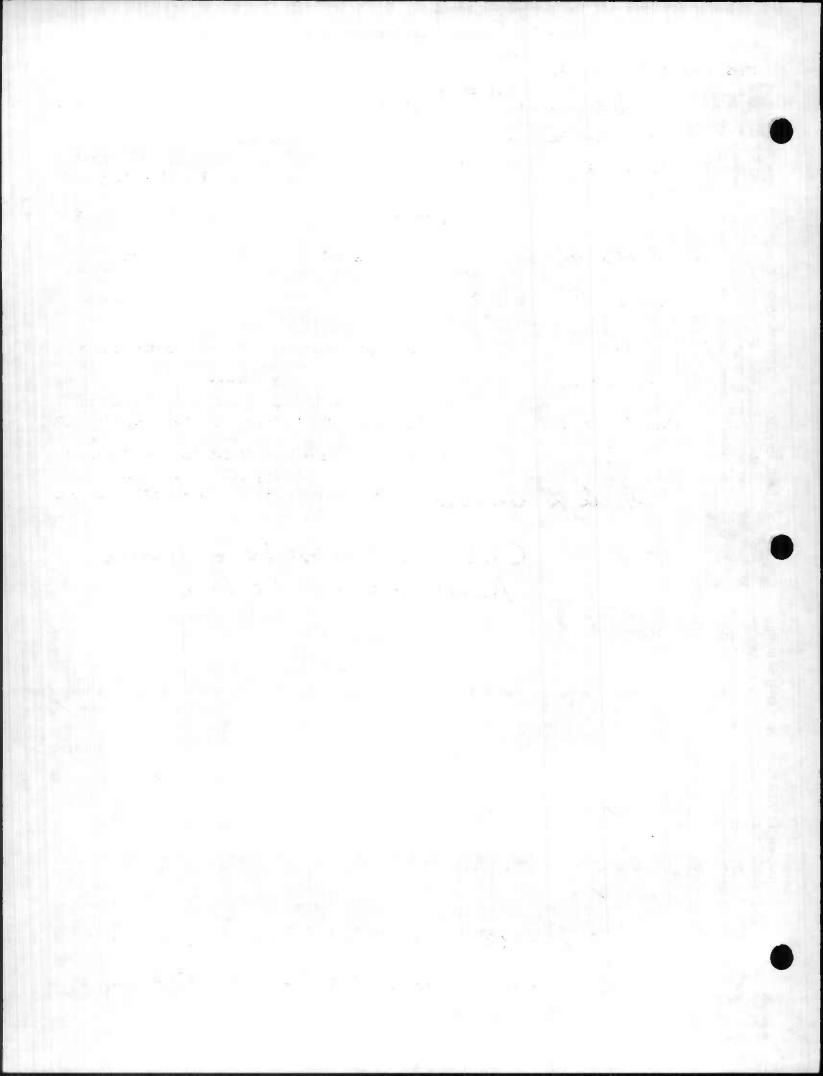
Spark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 den

Baltinine MD 2/20

Registrar

31. Date filed (Month, Day, Year) APR 2 6 1999 32 Registrar's Signature



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month April 23, 1999 Donna Sue Brissey 1:20 am 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 6029 Chesworth Road Catonsville **Baltimore** If Under 24 Hrs. 8. Date of Birth April 22, 1954 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Mary Land Days 216-68-4636 1 M 2 F Months Hours 45 Yrs Usuel Residence of Decedent 10a. Stete MD 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6029 Chesworth Road 21228 U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ② No If Yes, Give 1 Never Married 2 Merried specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Account Adjuster/Collector Medical Field 17. Fether's Neme (First, Middle, Last)
James E. Cadd 18. Mother's Name (First, Middle, Meiden Sumame)
Gertrude Wilkerson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judy Martin (Sister) 1250 Collier Lane, Belcamp, MD 21017 20b. Plece of Disposition (Name of cametery, cremetory or other plece)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlel 2 □ Cremation 3 □ Removel from State 4/27/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Service Licenses 1630 Edmondson Avenue, Catonsville, MD 21228 Lemmer 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final Primary Pulmonary Hypertension disease or condition resulting in deeth) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es a consequence of): Congestive Cardiac Failure Due to (or es e consequence of) Hypertension Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1⊠ Yes 2□ No 3 Probably 4 Unknown Super Morbid Obesity, Tobacco Abuse 24b. Were autopsy findings available prior to completion of cause of death? Major Depression, Anxiety Disorder 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Examiner Physician/Medical Examiner physician and the burial-transit P.O. Box 68760 been signed by the atter should be detached for Division of Vital Records. certificate or Attending Physician: funeral director, e Hospital or Attending n 24 hours after death. e Funeral Director: Aft filled in by

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23s or 28s-1 show any lighty or other traumatic event, the Wades Errother master notified at once.

21215-0020

Baltimore, Maryland

þ Completed Diabetes Mellitus 25. Wes case referred to medical axaminar? Be Medical Certification: To 1 Yes 2€ No 27. Manner of Deeth 5 Pending investigation 1 Netural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide 18 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier

Rhoppen MD

29c. License number D0051228 29d. Dete signed (Month, Day, Year) 4-23-1999

281. Location (Street and Number or Rural Route Number, City or Town, State)

RAMANA GUPALAN MD 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) WEST ROLLING CROSS POADS BALTIMORE

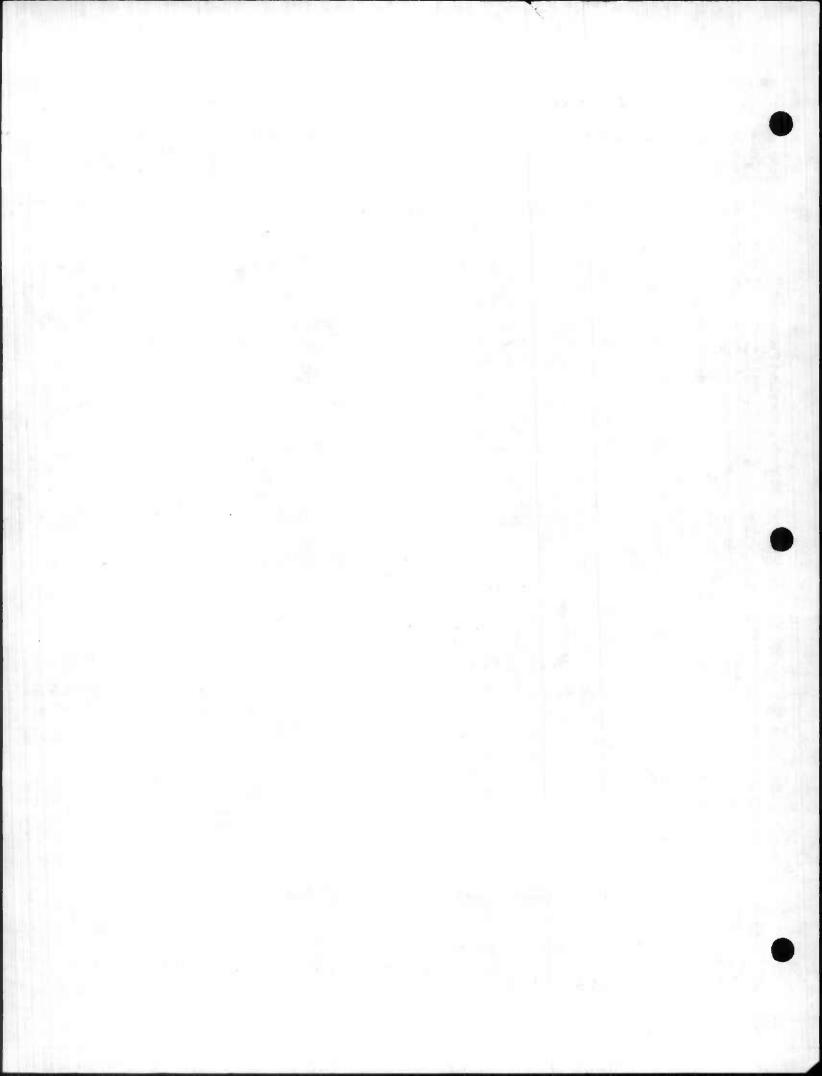
31. Date filed (Month, Dey, Year) State APR 2 6 1999 Registrar

32 Registrar's Signeture

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completely

To the I within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth Dev Year Month **Physician** 23, 1999 LILLIAN R. BOKMAN April 7:31am /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** 8561 CHRIS CT. PASADENA If Under 24 Hrs. 6 6. Date of Birth (Month, Day, Year) March 25, 1937 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign **Funeral** Months Days 1 □ M 2 🗙 F Maryland 62 Director 212 34 8536 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylar 1 Tyes 2X No Pasadena Directo Maryland Anne Arundel 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? finer must be n U.S. 21122 8561 Chris Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status filed within 72 hours after 1 ☐ Yas 2 X No 1 ☐ Never Merried 2 ☐ Merried b altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 6th College (1-4or 5+) Seamstress Sewing Factory 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Lillian E. Giles Wilbur Combes 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Hitem 27 is or other tra Cynthia Blackett / Daughter 8561 Chris Court Pasadena, Maryland 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, Steta 20e. Method of Disposition tery, cremetory or other place) 1 XBurial 2 Cramation 3 Ramoval from State Department of important: If any injury or 4/27/99 Sykesville, Maryland Lakeview Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 mamusuras 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 3 months diseese or condition resulting in death) Examiner Examiner caveinoma the burial-transit Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last The law requires that the death certificate be exec Box 68760. Physician/Medical Due to (or as e con 80 980 signed by the atte 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown p Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 □Yas 2 □ No certificate of Vital or Attending Physician: director 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division After 1 Meturel 5 Pending Ne Hospital or Attending in 24 hours after death. 1 Yes 2 No invastigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier completely (Check only one) Within 2 29d. Data signed (Month, Dey, Year) 29b. Signature and fitle of certifier SILVINO B. MUNESES, M. 139cp ignse number Man A721 Potes Street BALTIMORE, MD 2122 30. Name and address of person who completed cause of death (410) 235 544.34nt)

State Registrar

31. Dete tiled (Month, Day, Year) APR 2 6 1999

32. Registrer's Signatura

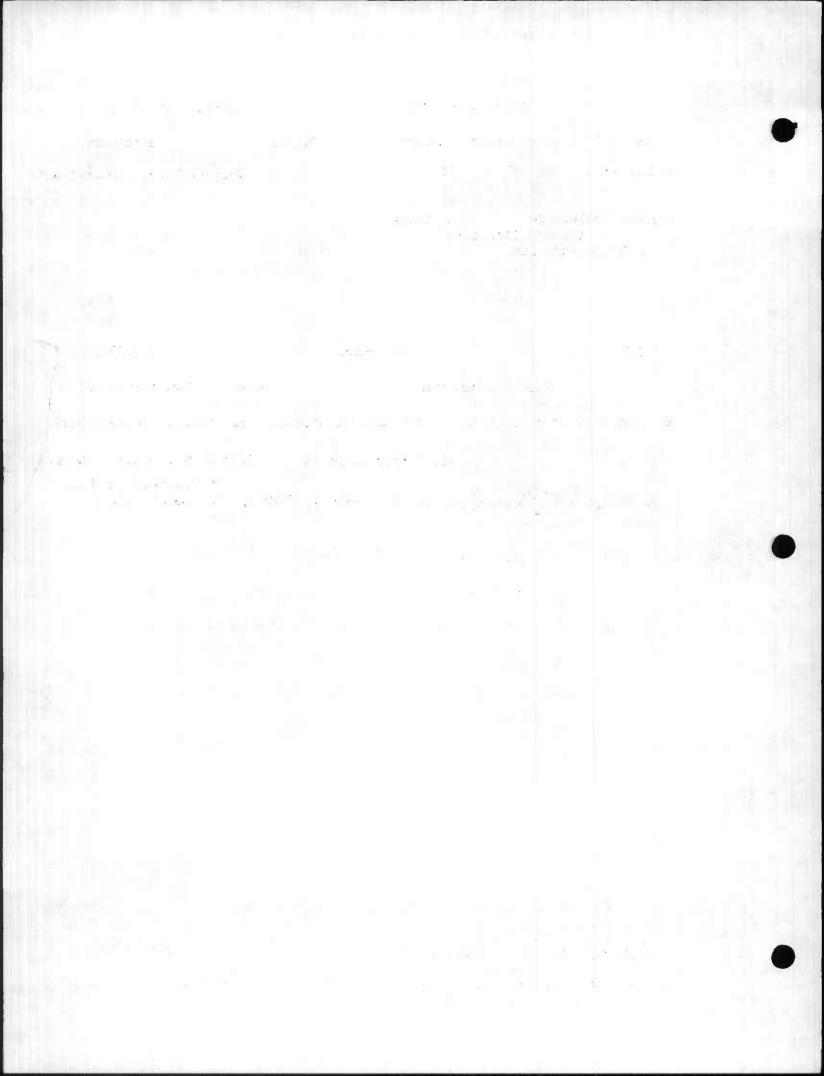
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SILVINO B. MUNESES, M.D., P.A. 3721 Polee Street BALTIMORE, MD 21221 (410) 35-3131

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State of Maryland / Department of Health and Mental Hygiene

| | Decedent's Name (First, Middle, Las | () | Cert | ificate of | Death | 2. Data of Dea | leg. No.9 9 | 3 L 7 |
|---|--|---|---|--|---|--|-----------------------------|--|
| Physician | | Anna L. Bo | ttari | | | Month April | Dey 21 1 | Yaar 999 7:21 P.N |
| · /Medical Examiner | 4e Facility Neme (If not institution, giva | street end number) | | | 4b. City, Town, or | Location of Death | | |
| LXammer | Genesis Elderca | re Heritage (| Center | | Dundalk Baltimor | | | timore |
| Funeral Director | 100 20 4574 | x ☐ M 2 F 7. Age (In yr 93 | s. last birthday) Yrs. | If Under 1 Year Months Deys | r If Under 24 Hrs Hours Min | | Year) | 9. Birthplaca (Stete or Fore Country) Pennsylvania |
| ž | Usuel Residence of Decedent 10a. State 10b. County | 10c. (| City, Town or Loca | alion | | | | 10d. Inside City Lim |
| 28a-f ahow notified at | Maryland Baltimor | | oundalk | | | | | 1 □ Yas 2 📉 |
| 5 6 | 10e. Street and Number Genes 7232 German Hill | is Eldercare Road | | 10f. Zip Coda 2 | 1222 | 1 | U.S | |
| 5 E | 11. Marital Status 1 Never Merried 2 Married 3 Vidowed 4 Divorced | 12. Was Decedant Evar in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: | | es Decedent of Yes, specify Cul | Hispanic Origin? (Spen, Maxican, Puer Specify: | Specify Yas or No- rto Rican, etc.) | 14. Race Bleck | - Amarican Indian, k, White, etc. White |
| lygiene. "natural", o nt, tre Medical Exer Completed by | 15. Decedent's Edi (Specify only highest grad Elementary/Secondery (0-12) | ucation fe completed) College (1-4or 5+) | 16e. Decedent's Usual Oc (Give kind of work do life. DO NOT use re Homemaker | | Occupation done during most of working retired) | | 16b. Kind of Bu | sinass/Industry |
| other to vent, in | 17. Fether's Neme (First, Middle, Last) | | 110418 | -HOLINGE | 18 Mother's Na | me (First, Middle, | | |
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| marked matic e | | | | 4 dd (Ct | | | | · · · · · · · · · · · · · · · · · · · |
| h and I la ma traum | 19e. Informant's Name/Reletionship (T Theresa Stevens | | | amrose | Aronuo | | | |
| f Health and Mer tern 27 Is marke other traumatic | 20a. Method of Disposition | | . Place of Dispos | | Avenue | Date | | yland 21225 City or Town, State |
| 6 = 5 | 1 M Burial 2 □ Cremetion 3 □ I 4 □ Donetion 5 □ Other (Specify, | Removei from State | cematery, creme t. Peter | etory or other pl | | | | mel, Penna. |
| Department important: any injury pnce. | 23a. Part1. Entar tha disease, or or the shock, or heart failure. List don't | imore, N | eral Home P.A. ore, Md. 21225 Approximeta Intervel Between | | | | | |
| g physician and as the burial-transit as the dicai Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest | b. CHRONIC Due to | (or as a consequ (or es e consequ | PRUCTONCE OF STREET OF STR | TIVE PU | LMOYAR | y DISEA | |
| 0100 | | d | | | | ant Mida | | |
| igned by the attandin be detached for use by Physician/N | Pert II. Other significant conditions co | ntributing to death but not r | esuiting in the uni | seriying cause g | iven in Pert I. | | obacco use con ∕ss 2□ No | atributs to the causs of de 3 Probably 4 Unki |
| 2 should | | | | | | 24e. Wes e | en autopsy med? | 24b. Were sutopsy findin aveilable prior to completion of cause of death? |
| s certificate hadirector, page | | | | | | 1 🗆 Y | es 2 70 | 1 ☐ Yes 2 No |
| certificate rector, pag | 25. Wes case refarred to medical axaminer? | | 26. Piace of De | eth (Check only or | ne) | | | |
| 五百 | 1 Yas 2 No 27. Menner of Death 1 Maturel 5 Pending 2 Accident investigation | 1 □ Inpatient 2 | ospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M | | | g Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred | | |
| within 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - Al building, etc. (Spe | home, farm, stre- cify) | et, factory, office | 9 | 28f. Location (S City or Tow | | er or Rural Route Number, |
| n 24 hou ne Funer pletely fill edical | | sician: To the best of my k ner: On the basis of exami end menner steted. | | | | | | |
| withi Comp | 29b. Signeture end title of certifiar | | | 29c. Licer | nse number | 1 | 29d. Dete signed | (Month, Dey, Year) |
| | Farinde | 1071,011 | M.n | No. | 27188 | | 4/23 | 185 |
| 3 | 30. Name and eddress of person who c | ompleted cause of deeth (If | tem 23e) (Type, P | rint) | er Plen | e Sulti | vere t | W 24222 |
| State Registrar | 31, Deta filed (Month, Day, Year) | 2. Ragistrer's Sig | neture | 1 | 4 | | | |

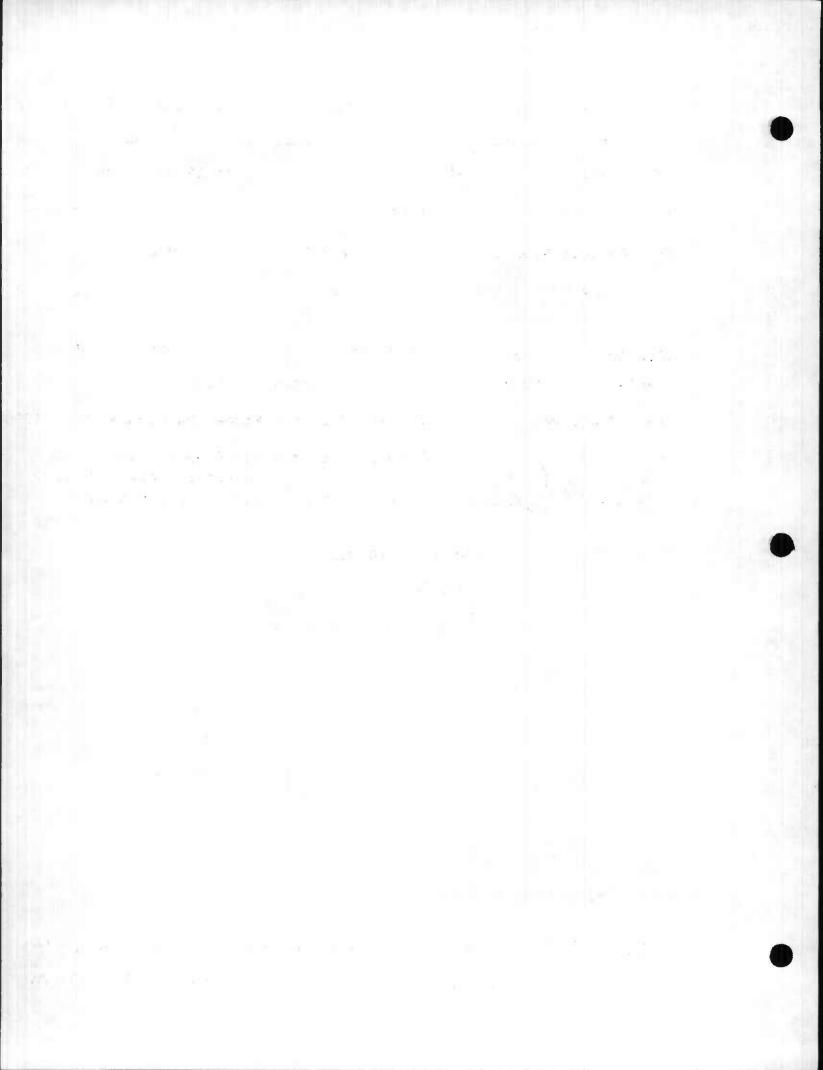


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 2/ 99 4c. County of Death 12 GAYHEART OOK 04 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) **Examiner** BonSecour Hospital Baltimore NA If Undar 24 Hrs. If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. 217-34-7724 Director 11-16-39 VA Usual Rasidanca of Decadant with the Meryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic svent, the Medical Examinal must be notified at MD NA Baltimore 1 X Yas 2 □ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2338 Garrett Avenue 21218 USA Funeral death Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S Armed Forcas? hours efter 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify: Black ģ 3 Widowed 4 Divorced Completed 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiana. Elamantary/Secondary (0-12) Collega (1-4or 5+) Laborer Patriarch Co. 10th Grade NA Departs. Pages 1 and 2 should be fit.
Department of Heelth and Mantal Hy, important If Nem Z7 is marked other any Injury or other transments. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Daniel Cook Sarah Cook 10 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 238 St. Matthews Street Baltimore, MD. 21239 Cassandra Young 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Baltimore Cemetery 04-26-99 Baltimore, MD re of Funeral Serv 22. Nama and Addrass of Facility Baltimore, Maryland 21202 Due WM.C.March FH 1101 E. North Avenue Part / Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death **Physician** fmmediata Causa (Finat disaasa or condition rasulting in daath) /Medical Examiner Dua to for as a consequence of): Examiner cartificate be axecuted Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury and burial-trar Dua to (or as a consequence of) physician Physician/Medical that initiated avants Due to (or as a consequence of): the rasulting in daath) Last usa as signed by the a 23b. Did tobacco use contribute to the cause of death? Part ft. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown P 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 🗆 Yas 2010 1 Yas 2□ No cartificate Division of Vital Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Chack only ona) Hospitat Other: 4 Nursing Homa 5 Residence 6 Other (Specify) To 1 Yas 2 No 1 Impatiant 2 ER/Outpatient 3 DOA Aftar this 28b. Tima of Injury 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Attending Natural 5 Panding invastigation e Hospital or Attending n 24 hours after death. e Funeral Director: Afte 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) vd ni bellii 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian edical within 2 To the 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) BALTIMORE. MO OBAZEE MR-EDWARD N.E AW ST. #407. 31. Data fited (Month, Day, Year) 32. Ragtstrar's Signatura State

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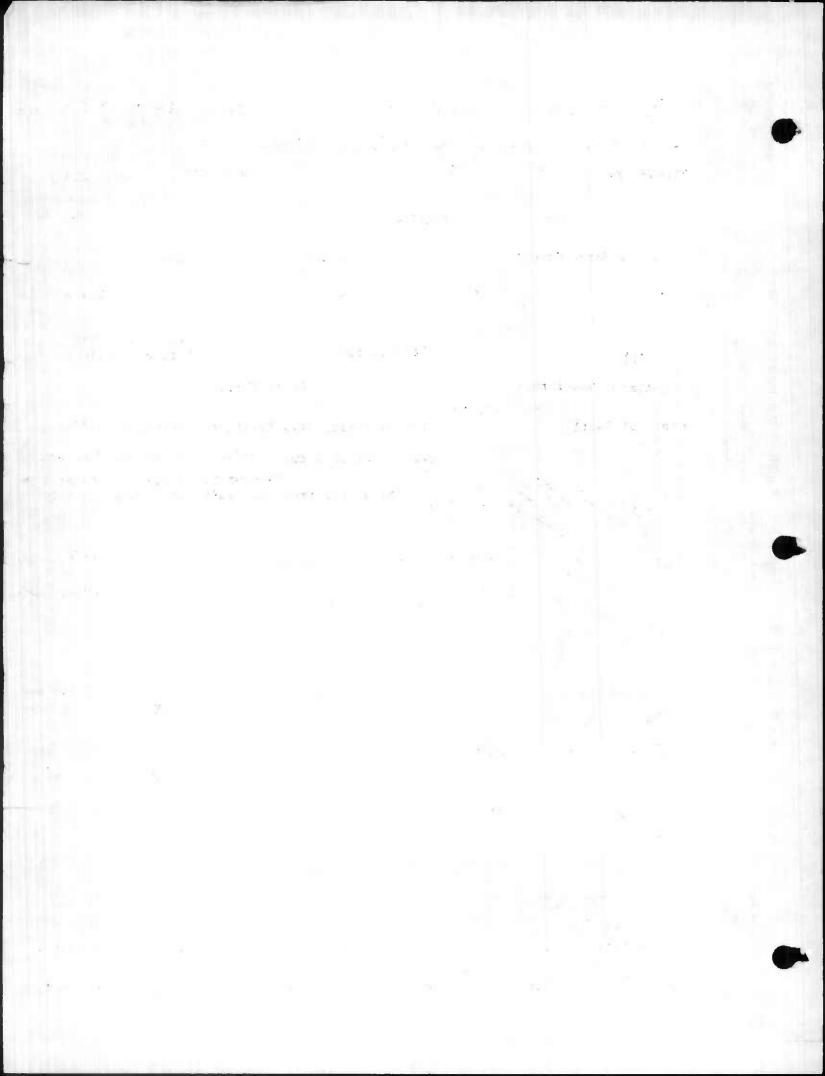
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 3:45 am 1999 JANFARANI 24 APRIL RENEDEMO /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMOVE
If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) JOHNSHOPKINS BAYLIEN MEDICAL If Under 1 Ye Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1**℃** M 2□ F Months Deys 86 Yrs 4-2-1913 Director 216-36-8310 Sora, Italy Usual Residence of Decedent with the Meryland 10d. Inelde City Limita r 28a-f show 10a State 10h County 10c. City. Town or Location MD 1 Yea 2 □ No n/a Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23s or pemit. Pagas 1 and 2 should be filed within 72 hours after daeth 1 Department of Haalth and Mentel Hygiena. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other traumatic event, the Medical Example page. 211 S. Eaton Street 21224 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2K No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bureau of Parks Elementery/Secondary (0-12) College (1-4or 5+) Landscaping 6th City of Baltimore 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Cianfarani Giuliano Lucia Ferri 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) nephew 206 S. Fagley St., Baltimore, Maryland 21224
Loc of Disposition (Neme of Dete 20c. Locetion - City or Town, Stete Gino Polsinelli 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4/26/99 Baltimore, Maryland Sacred Heart of Jesus 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licent 22. Name end Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224 Do not enter the mode of dying, such ea cardiec or respiretory errest, s thet caused the deserving on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel dis-e or condition resume in deeth) /Medical ardiac Arrhythmio 1-2 minutes Examine Due to (or es e consequence of) Examiner andiomy opath 1-2 months physician and s the buriel-transit law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated eventa resulting in deeth) Last P.O. Box 68760. Physician/Medical Due to (or es e consequence of) ettending pl Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? tha hed s been signed by the should be dateched 1 Yee 2 No 3 Probably 4 Unknown Anemia Division of Vital Records, þ 24b. Were autopsy findinga evallable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy Failure to thrive is cartificate has t 1□ Yes 2 No Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To this funaral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred Aftar 5 Pending investigation 1 Neturel To the Hospital or Attendir within 24 hours after daeth.

To the Funeral Director: All completely filled in by the fu daeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 THomleide (2) Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner es stated.

2 Medical Examinar: On the best of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(a) end menner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture en hear Wolfe, MO person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end Wolfe 4940 Eastern Nie., Baltimore, Maryland 21224 31. Dete filed (Month, Dey, Year) 32. Régistrer's Signeture State APR 26 1999 Registrar



P.O. Box 68760 Records, Division of Vital

The law requires that the death certificate be executed physician er s the burial-t attending pl the bed signed by the been si ils certificate hes t I director, page 2 s Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica Nelly filled in by the funeral director, p. To the Hospital or within 24 hours eff To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Director

Funeral

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Completed

Be

the Maryland

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filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 ht. Department of Heelth and Mental Hygiene. Important: If fem 27 is marked other than "natur sny injury or other traumatic event, the Medical once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai p Completed Be 0 Certification: edical 29a. Cartifier

25. Wes case rafarred to medical axamina.?

1 Yas 2 No 27. Mannar of Death 1 Natural

2 Accident 3 Suicida

4 Homicide

5 Panding invastigation 6 Could not be

28a. Data of Injury (Month, Day Year) 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work?

1 Yas 2 No

1X Cartifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29b. Signatura and titla of contifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

aurren

D25759

april 3, 1999

30. Nama and addrass of person who completed cause of deeth (item 23e) (Type, Print)

Walter K. Naumann, M.D., PO Box 247, Accident MD 21520

State Registrar

31. Data filed (Month, Dey, Yaar) 1 1999

32. Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death CROCKETT Month, 20 **Physician** April /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Stella Maris at Mercy Hospital Baltimore N/A 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months 1□M 20 F Deys 216 20 3322 87 Nov. 14, 1911 West Virginia Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Maryland Anne Arundel Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? than "natural", or items 23s or the Medical Examiner must be 118 Camrose Avenue U.S. 21225 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: by White 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Clerk Clothing Cleaners 12th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 8 1 and 2 should be 1 Health and Mental Mae Miller Leroy Nutter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Health I Robert Gawthrop Baltimore, Maryland 21225 118 Camrose Avenue 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Pages 1 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from State 4/26/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 arris 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) [erebrovascular Accident /ivied car Examiner brillation Examiner tria the death certificate be executed physician end s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 80 for use as Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of the Ampula 2 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 1□ Yes 2DNo 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director. Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence (Specify) OL 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) Attending 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) Torres

no completed cause of deeth (Item 23e) (Type, Print)

82. Registrer's Signeture

ELDWAN

301 ST PAUL

Baltimore, Md

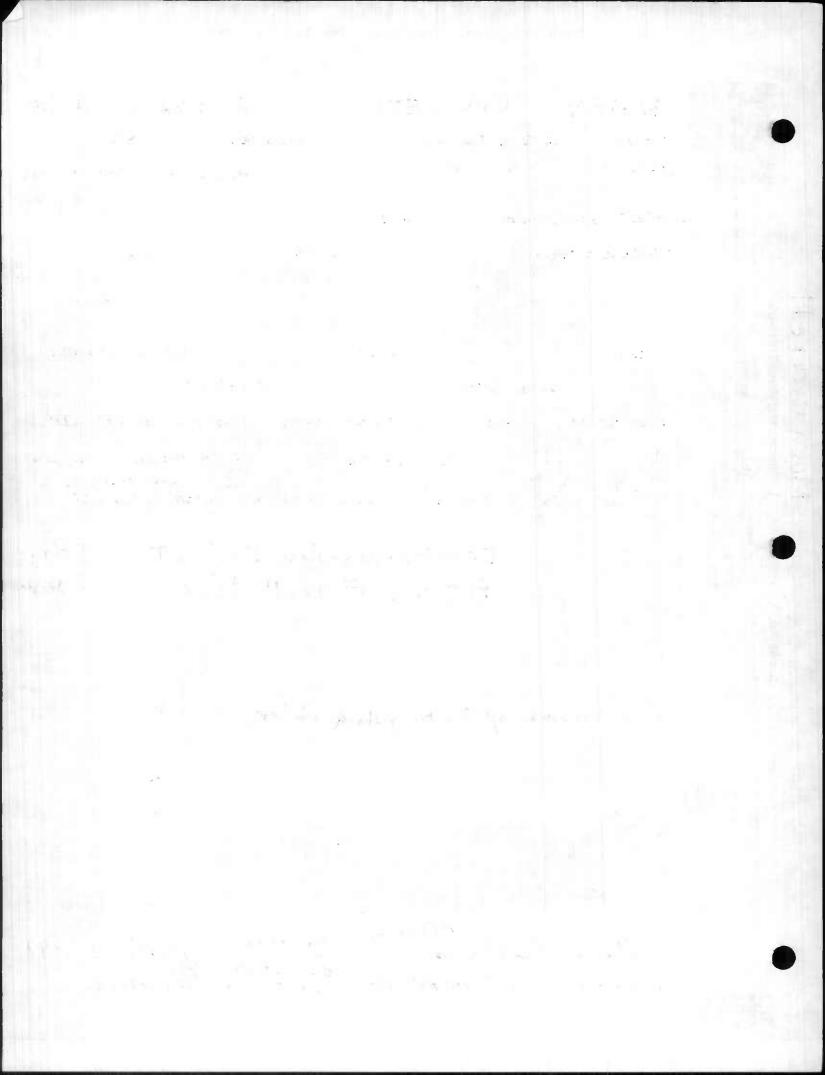
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State

30. Name and address of person y

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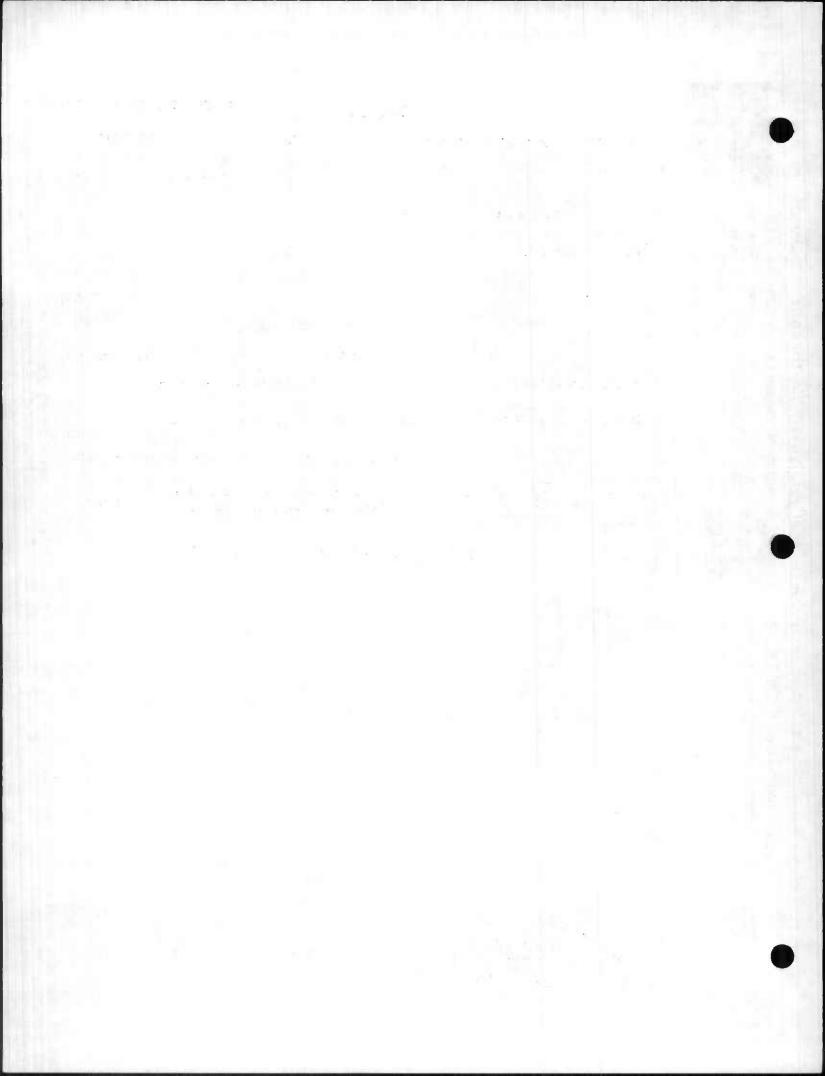
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month APRIL **Physician** 24, 1999 12:05PM Lawrence Coughlin /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, giva street and number) Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 4-26-12 Birthplece (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Deys 86 Yrs MD **Director** Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, or Medical Examiner must be notified at Baltimore MD Rosedale 1 Yes 2 No Director 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2316 Crossett Rd. 21237 USA Funeral 14. Rece - American Indien 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 3 Married 1 ☐ Yes 2 No Specify: white Coughlin, Lawrence à 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry filed within 7 I Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Heelth and Mental Hygien Important: If item 27 is marked other thy any injury or other traumatic event, If an once. Estimator Anchor Fence Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surnama) Joseph T. Coughlin Katherine B. Betz 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Marie C. Coughlin / wife 2316 Crossett Rd., Rosedale, MD 21237 20b. Piece of Disposition (Nama of cemetary, cramatory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 ☐ Cremetlon 3 ☐ Removel from Stete Gardens of Faith 4-27-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licanses 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** MOTOR NEURON DISEASE /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequenca of) 88 Pert fl. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t DNED MONIA ASPINATION 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy Completed peen has 24 hours after death.

Funeral Director: After this certificate it 1 Tyes 2 NO 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: 5 Pending Investigation 1 Naturei 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could nof be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steted. Medicai completely (Check only one) 2 Madical Exampler: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and menner stated. within 2 the 29d. Data signed Month. Day, Year) 29b. Signature and title of ogs 29c. License number 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) HERLINY TIMOTHY 10.0 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

APR 26 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ARLENE DEMPSEY 22-99 6:55pm /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHIE HOSPICE If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10 M 20 F 50 10-21-48 Director AUGUSTA 578-68-9348 GA. Usual Residence of Deceden the Maryland 10d. fnside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at 1 Yes 2 No Director WASHINGTON DC N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 7TH STREET 20001 U.S.A. Нета 23а Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status Black, White, etc. 72 hours after 1 Yes 2 No 1 ☐ ¥ever Married 2 ☐ Merried 21215-0020 Specify: BIACK "natural", or by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filled wi timent of Health and Mental Hygien tant; if item 27 is marked other th jury or other traumatic event, the TRANSPORTATION SER. 12 SELF EMPLOYED Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PEARL DAVIS COGIE BEAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) TONIA DEMPSEY BEAGLE DAU 176 PINECOVE AVE, ODENTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If Is any Injury or o Burial 2 Cremetion 3 Removal from State 4-27-99 WASHINGTON DC 4 □ Donation 5 □ Other (Specify) GLENWOOD CEMETERY o of Feneral Se 22. Name and Address of Facility
IJEROY O DYETT & SON FUNERAL HOME 4600 LIBERTY HGHTS AVE. BALTO. MD 21207 Part1. Enter the disease, of complications that caused in death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximete Interval Between Onset and Death **Physiclan** /Medical Immediate Cause (Final CARCINOMA WITH METASTASES PHNCREOS ZYRS disease or condition resulting in death) Examiner Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? O 1 | Yes 2 | No 3 | Probably 4 Onknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes 2□No 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HDSPICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ö 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Ahar 50 1 DNatural 5 Pending 1 Yes 2 No investigetion 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò 29a. Certifier ID certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 2 To the Forther Po 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number hus HPRIL 23 1999

State Registrar 31. Date filed (Month; Day, Year)

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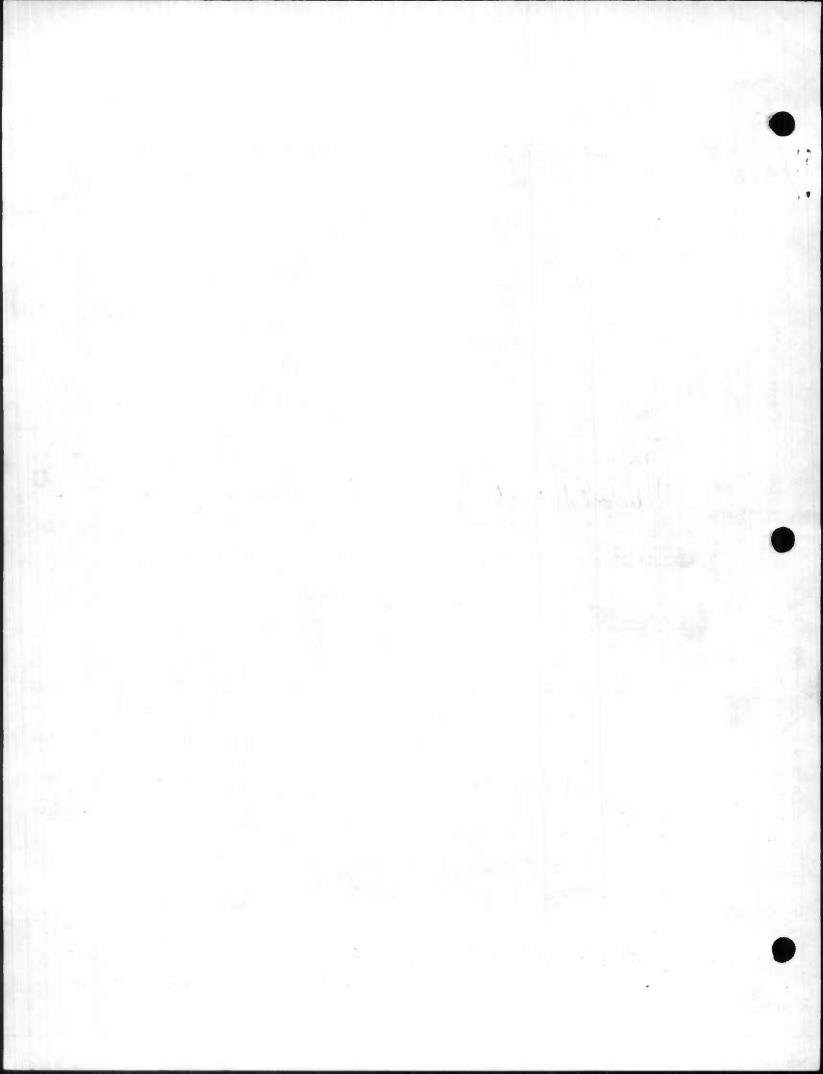
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29a. Certifier

200. Signature and title of certifier

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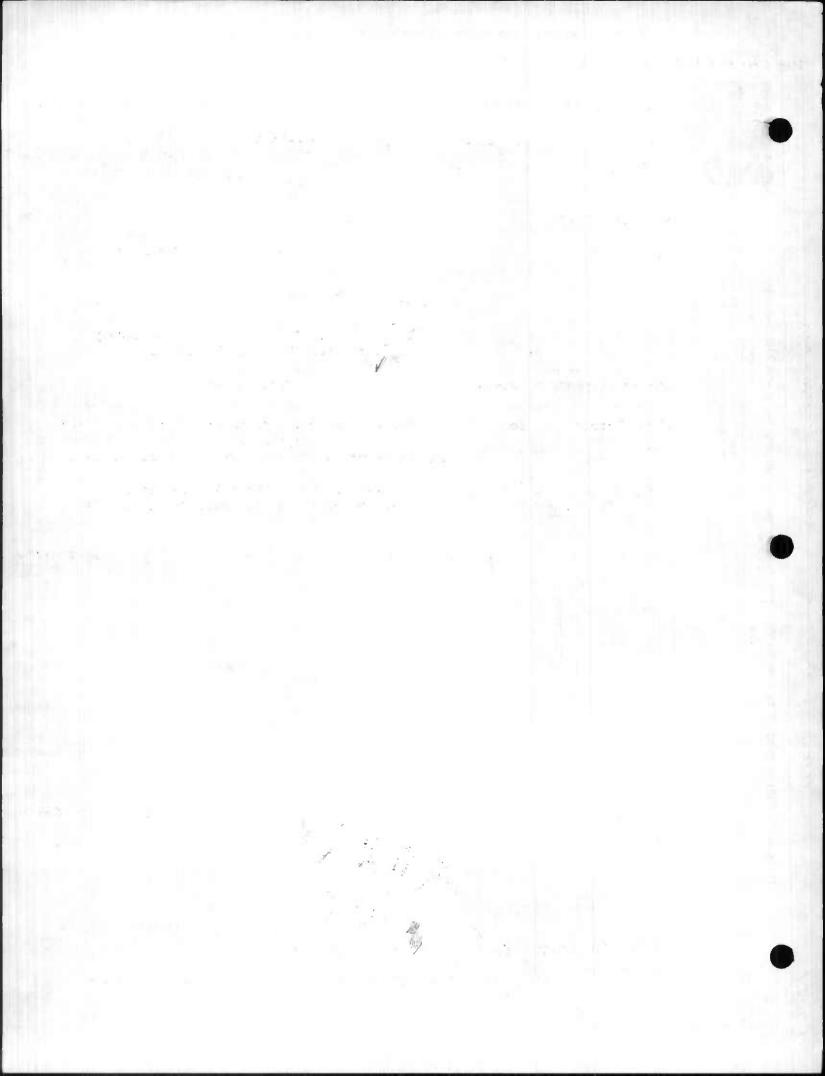
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1 D. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death **Physician** ROSE M. DONOHUE 0853 AM 21 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death **Examiner** Baltimore MARYLAND Balkimore Cutor UNIV. OF If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1 M 25F 577 07 3299 89 Yrs. Director April 4, 1910 Washington D.C. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at the Maryler ★ Yes 2 No Maryland Prince George's Bowie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "--- any injury or other traumest— any injury or other traumest— 20716 United States 16010 Excalibur Rd. #A 100 Funeral 14. Race - American Indian. 12. Wes Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yas ⊋☐ No If Yes, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married 1 Yes ₹ No Specify: Specify: White p 3 Midowed 4 ☐ Divorced Completed 16a. Dacedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) Elemantery/Secondary (0-12) College (1-4or 5+) 0 Salesperson Retail 18. Mother's Neme (First, Middla, Meiden Sumema) 17. Fethar's Name (First, Middla, Last) Unavailable Dijocomo Unavailable 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 4414 Orangewood Lane Bowie Maryland 20715 Son John Donohue 20b. Place of Disposition (Neme of cemetery, crematory or other place) April 24, 1999 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 Buriel 2 □ Cramation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Fort Lincoln Cemetery Brentwood Maryland 21. Signature of Funaral Sarvice Licenses 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23e. Part1. Enter the diseese, or complicator's thet ceused the death. Do not enter the mode of dying, euch es cerdiac or respiratory arrest, ahock, or heart feilure. List only one cause on eech line. Approximate tntarval Between Onset and Death **Physician** /Medical Immediata Cause (Finel diseese or condition resulting in death) I Week Sepsis Examiner month Examiner perforation Colon certificata be axecuted attending physician end for usa as the bunal-trend Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or es a consaguance of): Box 68760. Physician/Medical Due to (or as a consaquence of) 23b. Did tobacco usa contribute to the cause of death? Pert it. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert i. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to completion of ceuse of death? 24a. Was an autopsy Completed page 2 hes 1 Yes 2 No 2 NO 1 Yes 25. Wes cese referred to medical exeminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yas No 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datamined 28e. Plece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 24 hours 29a. Certifier 🕊 Certifying Physician: To the best of my knowledga, daath occurred et the time, dete end plece, end dua to the ceusa(s) and mannar as steted. Medical 2 Medical Examtner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) end manner stated. (Check only one) To the To the F 29d. Dete signed (Month, Day, Year) 4/21/99 29c. License number 29b. Signature and Tile of certifier P11411 or deeth (Ham 23a) (Type, Print) Greene Strutt; Dpt of Surgery ess of person 30. Name and addy 1/aral Man Ulniv.

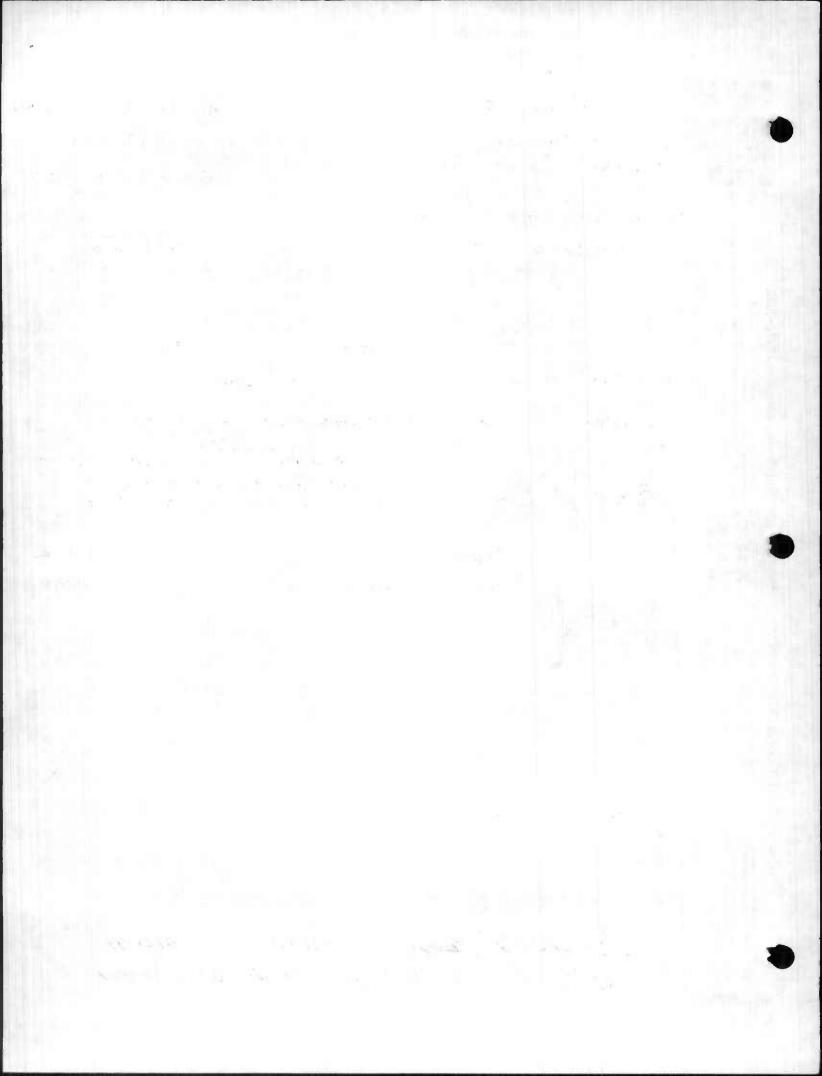
32. Registrar's Signature

State
Registrar

DHMH 16 Rav 6/95

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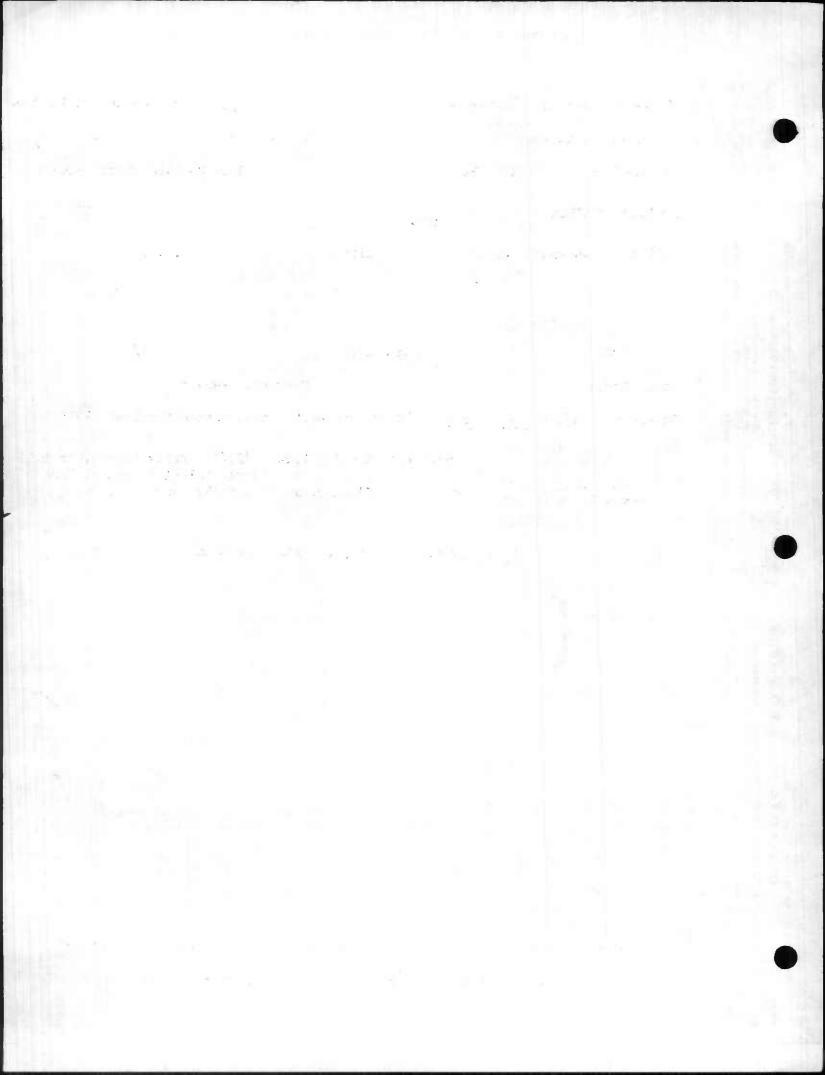
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State of Maryland / Department of Health and Mental Hygiene

| Physician | 1. Decedent's Name (First, Middle, Las Borboro Crowe | | 061 | tificate of | Death | 2. Date of De Month | Reg. No. ath Day | 3. Time of Death | |
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| te filed within 72 hours efter death with the Maryland el Hygiene. In Hygiene. Vent, the Medical Examinar must be notified at went, the Medical Examinar must be notified at Be Completed by Funeral Director | Usual Residence of Decedent 10a. Stete 10b. County Maryland Talbot | | y, Town or Loc | cation | | | | 10d. inside City Limi | |
| | 10e. Street and Number 408 c Goldsborou | gh Street | | 10f. Zip Code 21601 | | | U.S.A. | et Country? | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates: | | Vas Decedent of Yes, specify Cu | Hispanic Origin? (S ban, Mexicen, Puer Specify: | pecify Yes or No to Rican, etc.) | Biack, | American Indien, White, etc. White | |
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| Be ett | 17. Fether's Neme (First, Middle, Last) Percy Crewe | | 18. Mother's Name (First, Middle, Malden Sumame) Margaret Granger | | | | | | |
| and is m | 19a. Informant's Name/Relationship (7 Donald D. Donohue | | | | et and Number or Ricough Stre | | | | |
| Department of Health Important: If item 27 any followy or other to | 20e. Method of Disposition 1 XBurial 2 Cremetion 3 4 Donetion 5 Other (Specify | Removal from State | cemetery, crem itional | | al Park | | Falls C | ity or Town, State | |
| Department Important: any injury | 21. Signature of Funeral Service Licensee James G. Mc Taggart 22. Name end Address of Facility Everly Colonial F | | | | | | | | |
| hysician /Medical examiner | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finel disease or condition resulting in death) | · WOIDERST | | Mocr | | | | Interval Betweer Onset and Deetl | |
| nding physician and use as the buriel-transit | Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last | С | or es e conseq or as e consequ | | | | | | |
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| T dis | 1 Yes 2 No 27. Magner of Death 1 Naturel 5 Pending 2 Accident investigation | Hospitel: 1 Inpatient 2 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. In | | · · · · · · · · · · · · · · · · · · · | dence 6 Other | | |
| within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: | 3 Sulcide 6 Could not be determined | | | | 28f. Location (Street and Number or Rural Route N. City or Town, State) | | | | |
| 24 hour Funer etely fill | 29a. Certifier 1 Certifying Phyone) 2 Medical Exam | alcian: To the best of my kno iner: On the basis of examina end menner steted. | owledge, death ation and/or Inv | occurred at the restigation, in my | time, date and place opinion, death occ | e, and due to the urred at the time, | ceuse(s) end man date and plece, ar | ner as stated. ad due to the cause(s) | |
| To the comple | 29b. Signature and title of certifier What was a signature and address of person who come and address of person who come and address of person who come are signature. | | | | nse number | | | (Month, Day, Year) 7, 1999 | |
| | | | _ | | | | | | |

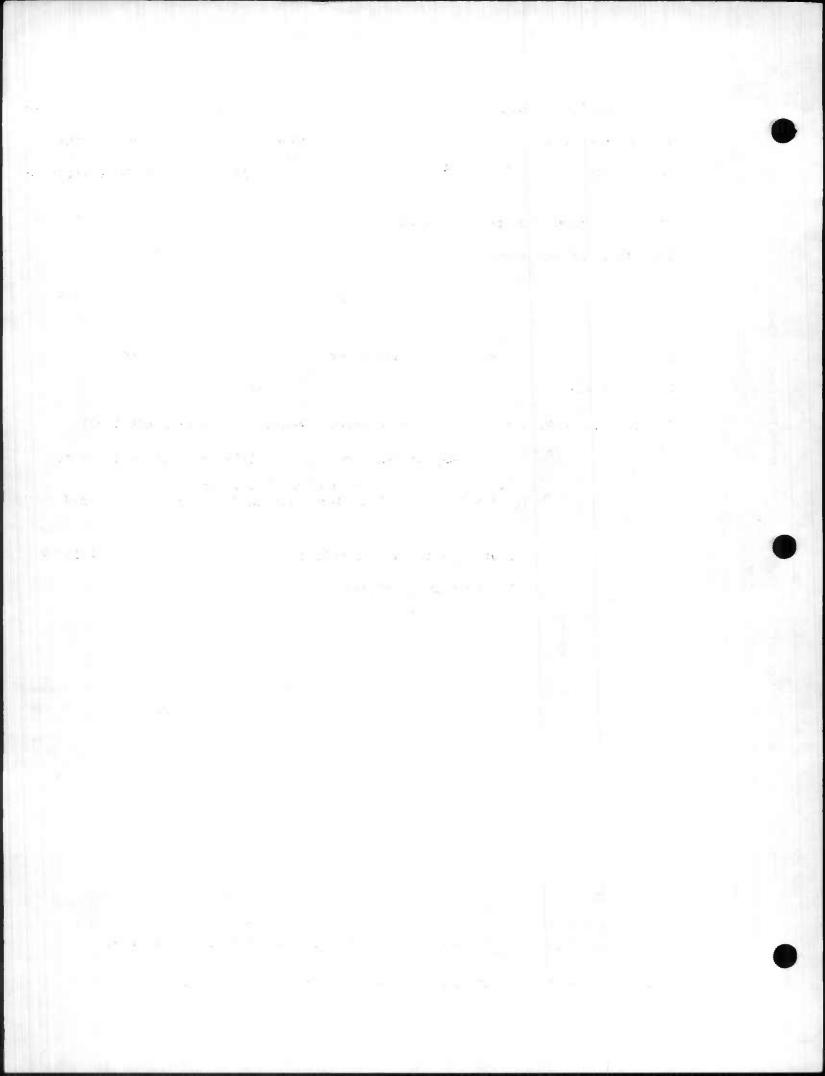


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dey Month **Physician** 3:01 p.m. April 15, 1999 Violet Maxine Emerson /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Lanham Prince George Doctors Hospital If Under 1 Year ff Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 X F Months Devs Hours Min. 74 Yrs. West Virginia Jan. 11, 1925 225-30-1215 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified. 10d Inside City Limits 10e Stete 10b. County 10c. City. Town or Location 1 Yes 2 □ No Director College Park Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 9321 Rhode Island Avenue 20740 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 1 Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Opel Sites Bruce Adamson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 4614 Linhoss Road, Dayton, Virginia 22821 Doris Marquess/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 N Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4/17/99 Dayton, Virginia Dayton Cemetery 22. Name and Address of Fecility
Fleck Funeral Home, Inc. 21, Signature of Funeral Service Licer 7601 Sandy Spring Road, Laurel, Maryland 20707 Mal anul 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or lear feilure. List only one ceuse on each line. Approximate interval Between Onset and Deetl **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) 04 15 99 Acute myocardial infarction Examiner Due to (or as a consequence of): Examiner Ischemic heart disease - fran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be execuphysician a s the burlai-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the causs of death? 8 6 1 Yss \$ No 3 Probably 4 Unknown signed to d be det þ 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24a. Was an eutopsy Completed Deen law. page 2 788 1 Yes 2 No 1□ Yes 2□ No certificate Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA 94 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affec Attending 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director: 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital
, within 24 hours at
To the Funeral C
completely filled 1XIC-artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number Exp. 29b. Signature and title of certifier D0013668 MD 09 30 00 04 16 99 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Azher Hussain, M. D. 4917 Edgewood Road, College Park, Maryland 20740 32. Registrar's Signature 31. Date filed (Month, Day, Year) State B. Sporks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Linda Fuchs L 24,1999 2:30am April 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Baltimore n/a Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours 1□ M 2X F Days 57 217 58 4255 Dec. 15, 1941 Ohio Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Center Place 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 30Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A 9 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Max Muniz Tice Rosetta 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Balch / Daughter 9102 Abigail Dr., Apt. 1C, Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Coremation 3 ☐ Removal from State Green Mount Cremation 4/27/99 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Applications are caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Applications are caused in the death. 21286 Approximate interval Between Onset and Death 2 days Immediata Cause (Final Aspiration disaasa or condition resulting in death) Due to (or as a consequence of): days small bowel obstruction Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): that initiated events resulting in deeth) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medicei axaminer? 26. Place of Death (Check only one) Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify) 1 Yas 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death cartificate be executed ician and burial-trans attending physician for use as the burie S signed by the a paga 2 has cartificata this funaral After

Physician

/Medical

Examiner

Directo

Funerai

þ

Completed

Funeral

Director

7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

the Maryland

with

death

parmit. Pages 1 and 2 should be filed within 72 hours after concentrant of Health and Mental Hygians. Important: if item 27 is marked other than any injury or other two.

Physician

Examiner

/Medicai

Physician/Medicai þ Completed Be Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Examiner

Division of Vital Records, P.O. Box 68760, or Attending s aftar daath. filled in by Hospital 24 hours within 2 the

> State Registrar

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Jodi Rennert-Ariev Johns Hopkins Bayview Medical Center, Baltimore 31. Date filed (Month, Day, Years 6 1999

ennut

32. Registrar's Signature Iner

Samo



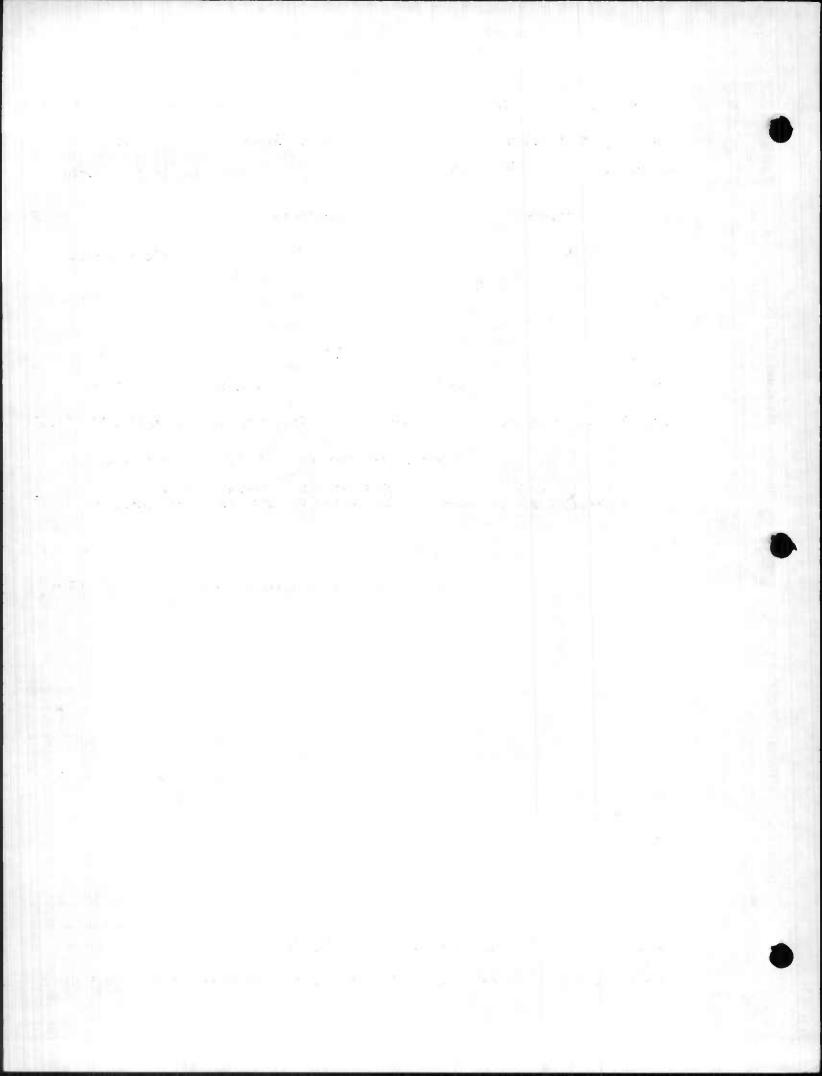
TX Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 29c. License number 96711

April 24, 1999

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 99

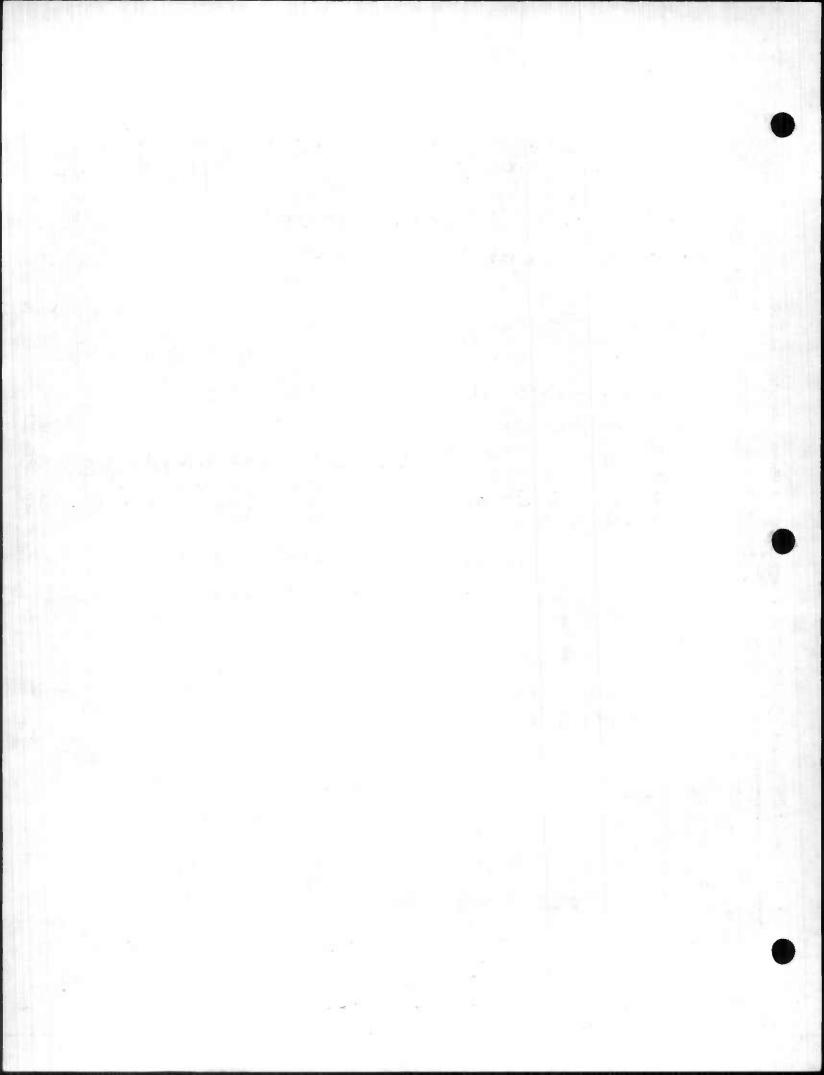
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| | | Certificate of Death | | Reg. No. | | | |
|---|--|---|-----------------------------------|---|--|--|--|
| 1. Decedent'a Name (First, Middle, Las | 11) | | 2. Dete of De Month | | 3. Tima of Death | | |
| Lacie | HEWS | | April | 20, 19 | 99 9:150 | | |
| 4a Facility Neme (If not institution, give | street and number) | 45 City, Ton | wn, or Location of Deat | | f Deeth | | |
| LIBERTY JU | earcar co | of birthday) If Under 1 Year If Under | timore | | 17 | | |
| Social Security Number 6. So | ex 7. Age (In yrs. las | Yrs. Months Days Hours | Min. 8. Dete of Bit (Month, De | 14 1910 | Birthplace (State or Forei Country) | | |
| 215-22-6209 11 | . 00 | | Dala | 14,1410 | VH | | |
| Da. State 10b. County | 10c. City, | Town or Location | | | 10d. Inside City Limi | | |
| M am | 7 6 | ACTIMOR | E | | 12 Yes 2 N | | |
| 0e. Street and Number | 0 | 10f. Zip Code | | 10g. Citizen of WI | nat Country? | | |
| Min Deard | Yklake DR. | 21217 | | USI | 7 | | |
| 11. Merital Status | 12. Was Decedent Ever in U,S. Armed Forces? | 13. Wes Decedent of Hispanic Original In Yes, specify Cuban, Mexican | gin? (Specify Yes or No | | - American Indien, White, etc. | | |
| 1 Never Merried 2 Merried | 1 Yes 20 No | 1 ☐ Yes 2 No Specify: | , I don'to I hour, o'co. | Specify: | 0 | | |
| 3 XWidowed 4 □ Divorced | Year or Detes: | 13.00 | | | DIACK | | |
| 15. Decedent's Ed (Specify only highest grad | | 16a. Decedent's Usual Occupation (Give kind of work done during most | t of working | 16b. Kind of Bus | Hopkins | | |
| Elementary/Secondary (0-12) | College (1-4or 5+) | (life. DO NOT use retired) | 4.01= | | | | |
| 17. Fether's Name (First, Middle, Last) | NA | 18 Mother | or's Neme (First, Middle | | ersity | | |
| 1 5000 06 | NSON | 0 | | Cal | , , | | |
| 19e. Informent's Neme/Relationship (7 | | 19b. Mailing Address (Street and Number | DECCA | | State, Zin Code) | | |
| MARTHO Stei | wart-Dava | 319 K. Alleno | 1-1-1 | Do 1th | MD. 2172 | | |
| 20a. Method of Disposition | 26b. Pla | ce of Disposition (Name of | Dete | 20c. Location - C | City or Town, State | | |
| 1 Buriat 2 Cremetion 3 4 Donation 5 Other (Specify | Hemovel from Stele | netery, cremetory or other place) | 1424.99 | ford- | Mataria M | | |
| 21. Signature of Funerat Service Licens | 17.100 | 22. Nome and Address of Fecility | | Tanou | 7.1000 | | |
| Min. R | i show | march, Fun | reral Ho | BEM. | 11 1NC | | |
| 23a, Part1, Enter the disease, or common | plications that caused the deeth. | Do not enter the mode of dying, such as | cardiac or respiratory | Da Fo. | Approximate | | |
| shock, or heart sailure. List only o | ne cause on each line. | | | | Approximate tnterval Between Onset end Death | | |
| tmmediate Cause (Final disease or condition | A. 1 | m. 1.00 | 1 1/10 | 11. | Idan | | |
| resulting in death) | a. Due to for a | as a consequence of): | 77900 | was . | 7 | | |
| | . Col11 | naus Aller | 1 Duses | 2/2 | 19 | | |
| Sequentially list conditions, | Due to (or a | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | |
| thet initiated events resulting in death) Last | Due to (or a | s a consequence of): | | | | | |
| | d | | | | | | |
| | | | | | | | |
| Pert It. Other significant conditions co | ntributing to death but not result | ing in the underlying cause given in Pert I. | . 23b. Did | | tributa to the cause of deat | | |
| Demons | ig | | 10 | Yea 2000 | 3 Probably 4 Unkno | | |
| | | | 242 Was | an eutopsy | 24b. Were eutopsy finding | | |
| | | | | ormed? | eveileble prior to completion of cause | | |
| | | | | -5/ | of death? | | |
| or we will be a second to the first | | | 10 | | 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? | Hospitel: | 0.1 | of Deeth (Check only | | (O | | |
| 27. Manner of Death | | ENOutpatient 3L DOA BLENursing Home 5 L Residence 6 Liother (Specify) | | | | | |
| ONaturel 5 ☐ Pending investigation | | 8b. Time of tnjury Mork? M 28c. Injury et Work? 1 Yes 2 1 | No | | | | |
| 3 Suicide 6 Coutd not be | 28e. Plece of Injury - At hom | e, ferm, street, fectory, office | 28f. Location | 28f. Location (Street and Number or Rural Route Number, | | | |
| 4 Homicide | building, etc. (Specify) | | City or To | City or Town, Stele) | | | |
| 29e. Certifier Certifying Phy | valcian: To the best of my knowle | edge, death occurred et the time, date and | d place, end due to the | cause(s) and man | ner as stated. | | |
| (Check only 2 Medical Examone) | iner: On the basis of examinetio and manner steted. | n and/or investigation, in my opinion, deat | th occurred at the time, | date end place, a | nd due to the cause(s) | | |
| 29b. Signeture end title of certifier | 0 | 29c. License number | | 29d. Date signed | (Month, Dey, Year) | | |
| | 1/ | 1)72 | 44 | 7/3 | 73/8 | | |
| 30. Name and address of person who c | ompleted cause of death (Item 2 | 3a) (Type, Print) | | | 2/2/ | | |
| | nresm | ion mo | 2600 h | berty H | eights Balto, | | |
| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signatur | 10 | | | - /- | | |

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Registrar

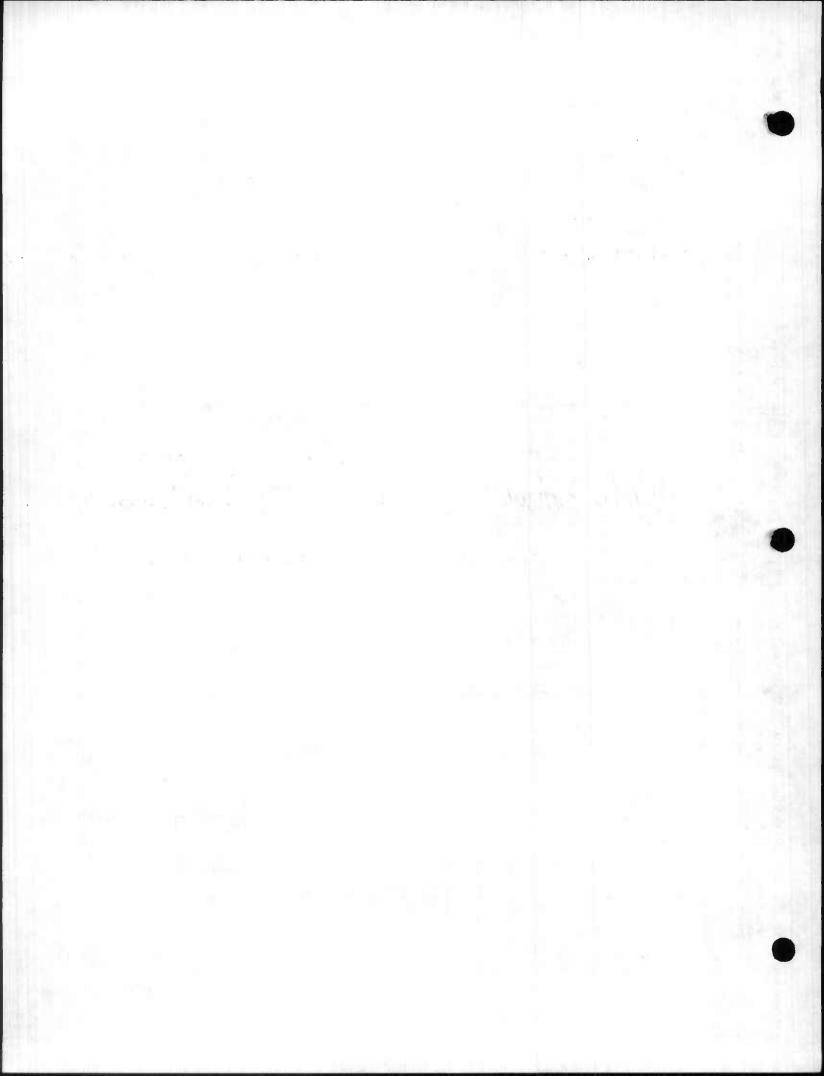
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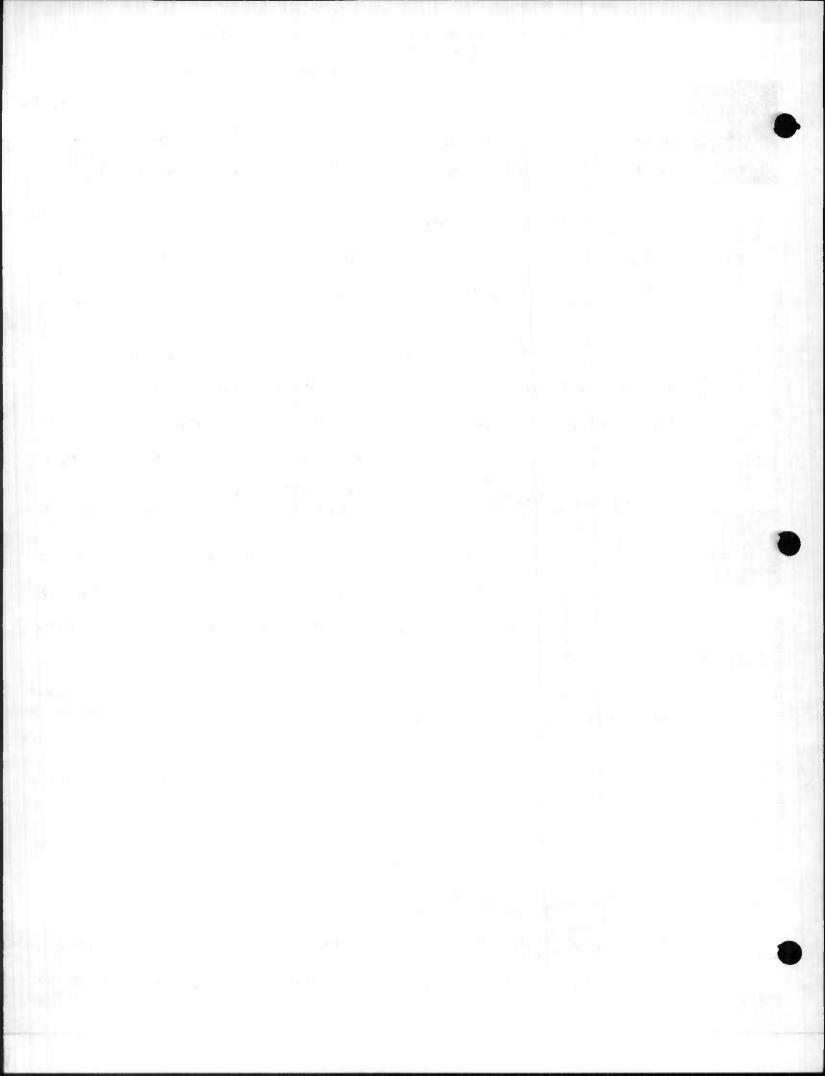
State of Maryland / Department of Health and Mental Hygiene 9 9 3 4 8 4

| 1. Decedent's Name (First, Mick | | | Ociumo | ale of | Death | | Reg | . No. | | | |
|--|--|---|--|---|--|--|---|---|----------------------------|--|--|
| | ile, Last) | | 1745 | | | | Date of Death | Davi | Vana | 3. Tima of Death | |
| a broader billin | | | | | Month | onth Day Year | | 6:00am | | | |
| al FEANCES FINN 4s Facility Name (If not institution | | number) | | | 4b. City, To | wn, or Locatio | on of Death | 4c. County | | O:OUAM | |
| | | | | | D. 7 m | _ | | | | mar | |
| 3611 MOHAWK 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last hirthday) If U | nder 1 Year | BALT If Under | 24 Hrs. R r | Tate of Rinth | BALTO | | TY aca (Stata or Foraign | |
| | 10 M 20 F | | Yrs. Mor | ths Days | Hours | Min. | Month, Day, Y. 8 / 1 1 | ear) | Count | ry) | |
| 220-14-3270 Usual Residence of Decedent | | 88 | | | | 17 | 0/11 | | Alla | BAMA | |
| 10a. State 10b. Count | у | 10c. City | y, Town or Location | | | | | | 10 | d. Inside City Limits | |
| 5 | | | 717.00 | | | | | | | 1 ☐ Yes 2 ☐ No | |
| MD N/ 10e. Street and Number | A | | BALTO. | . Zip Code | | | 100 | . Citizen of V | What Count | Λ | |
| | | | 10 | | 1015 | | Toy | | | . y . | |
| 3611 MOHAWK | | | | | 1215 | | | | S.A. | | |
| 3611 MOHAWK 11. Marital Status 1 Never Married 2 Ma | Armed | scedent Ever in U, Forces? | S. 13. Was D | specify Cubi | fispanic Ori an, Maxican | gin? (Specify , Puarto Rica | Yas or No- n, atc.) | | e - Amarica k, Whita, a | | |
| | If Yes, 6 | | 1 🗆 Y | s 2 No | Specify: | | | Specify | BI | ACK | |
| | d Year or | Dates: | | | | | | | | | |
| | nt's Education est grade complete | d) | 16a. Decedent's | f work dona | durina most | 16b. Kind of Business/Industry | | | ustry | | |
| Elementary/Secondary (0-12) | | (1-4or 5+) | lifa. DO NO | lifa. DO NOT use retired) | | | | | | | |
| 10 | | HOUSEV | | EWIFE | | | | HOUSE | | WIFE | |
| 17. Father's Name (First, Middla | , Last) | | 5-4 | | 18. Motha | r's Name (Fir | st, Middle, Ma | idan Sumam | a) | | |
| ABE AVERY | | TTAM | | | | ATTIE | TIE PEARL BLACK | | | | |
| 19a. Informant's Name/Ratation | ship (Type, Print) | | 19b. Meiling Add | irass (Street | and Numbe | r or Rural Ro | r Rural Route Number, City or Town, State, Zip Code) | | | | |
| MARY LITTLE | (NEICE) | | | | RTH | AVE, | BALTO, | , MD | 212 | 17 | |
| 20a. Method of Disposition | | 20b. P | tace of Disposition | (Neme of | | D | ata 20 | c. Location - | City or To | wn, Stata | |
| 1 ☑ Burial 2 ☐ Cremation | | m Stata | emetery, crematory | | | D 4 0 | | | | | |
| 4 Donation 5 Other (| | GAR | RISON F | OREST | CEM | E.4-Z | 2-99 (| DWING | MILL | I.S, MD | |
| 21. Signature of Hurriral Service | Licenson | 11 1 | / | a and Addra | | | | | | | |
| MILLEY | Strul | y y | | | | | ON FUI | | | | |
| 23a. Part1. Enter the disease, of shock, or heart failure. Lis | of complications that | t saused the dest | n. Do not enter the | moda of dyir | ng, such as | cardiac or ras | S AVE | BAL | 10. | MD 21207 Approximate | |
| shock, or heart failure. Lis | it only one cause or | each line. | | | | | | | ŧ | Intarval Batween Onsat and Daath | |
| Immediata Cause (Final | | | ^ | | | | | | | 1 | |
| disease or condition resulting in death) | . TRAI | USITION | or CGIC | CA | RCIA | Joma | oft | 3 CADI | DEV 1 | 6/4/5. | |
| | | Due to (o | r as e consequence | of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Indervino. | | | | | | | | | | | |
| Sequentially list conditions, | | Due to (or as a consequence of): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | | | | | | | | 1 | | |
| that initiated events resulting in death) Last | С. | Dua to (or | as a consequence | of): | | | | | | | |
| Cause (Disease or injury that initiated events resulting in death) Last | | | | | | 1 | | | | | |
| | d | | | | | | | | | | |
| Part II. Other elgolificant conditi | ions contributing to | ontributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause o | | | the cause of death | |
| | voin working to | | y iii ula unoany | ang odusa giv | on art art I | | | | . / | | |
| | | | | | | | 1 Yes 2 No 3 Probably | | ably 4 ☐ Unknow | | |
| | | | | | | | | | | | |
| | | | | | | _ - | 240 144 | nutor :: | 24h 14/- | re autoney findings | |
| | | | | | e d | | 24a. Was an a | autopsy d? | ava | ra autopsy findings illable prior to | |
| | | | | | <u>(Ú)</u> | | 24a. Was an a performe | autopsy d? | ava | | |
| | | | | | | | 24a. Was an a performe | autopsy d? | ava cor of c | idable prior to nptation of cause leeth? | |
| 25. Was case referred to medical | at | | | | 26 Diace | | performe | d? | ava cor of c | idable prior to nptation of cause leeth? | |
| 25. Was case referred to medical examiner? | Hospital: | | | Otto | ner: | of Death (Cr | performe 1 ☐ Yas neck only ona) | 212No | ava cor of c | illable prior to noptation of cause leeth? | |
| 25. Was case referred to medical examiner? | Hospital: 1 [| - | |] DOA Oth | ner: 4□ Nu | of Death (Cr | performe 1 ☐ Yas neck only ona) 5 ☐ Residence | 2 1 No 2 1 No 2 6 □ Oth | ava cor of c | illable prior to noptation of cause leeth? | |
| 25. Was case referred to medical examiner? | Hospital: 1 E | Inpatient 2 la of Injury onth, Day Year) | 28b. Tima of Injury | 28c. Injur | ner: 4□ Nu ry at rk? | of Death (Crising Homa 28d. | performe 1 ☐ Yas neck only ona) | 2 1 No 2 1 No 2 6 □ Oth | ava cor of c | illable prior to noptation of cause leeth? | |
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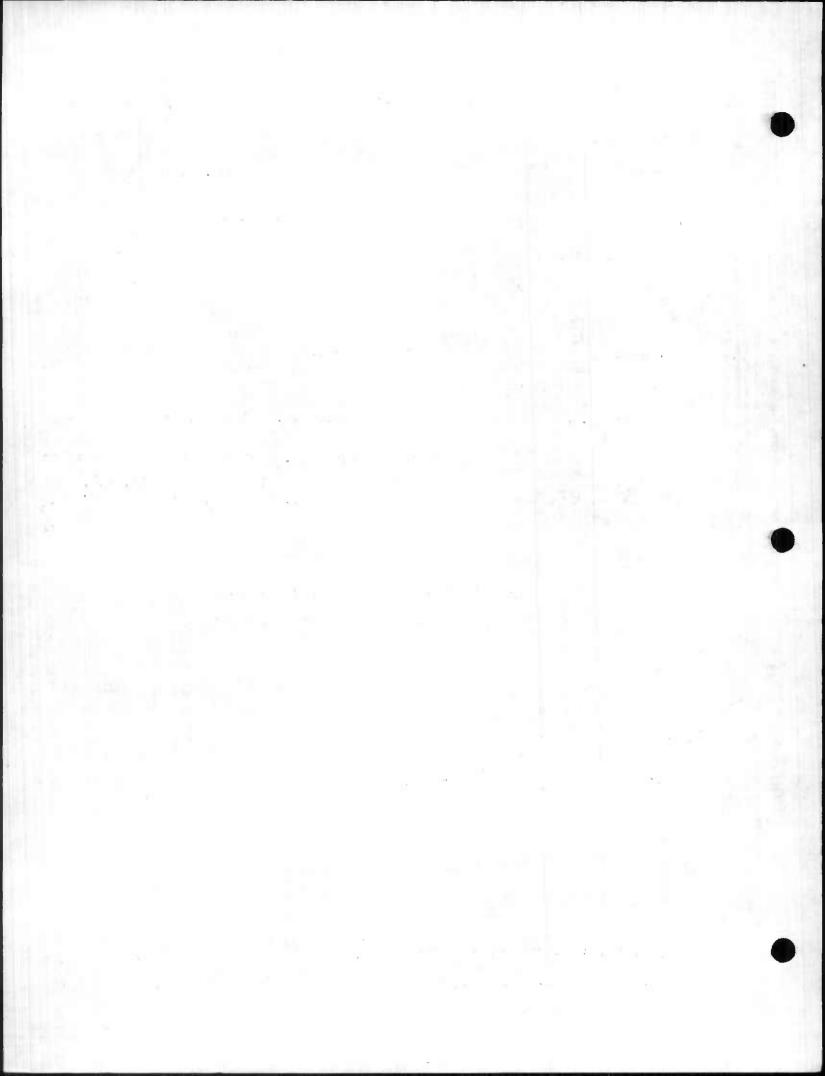
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| | a | 9705 Whiskey | Run | | | 2072 | 3 | | | USA | | | |
| | Iner | 11. Maritel Status | 12. Was De | ecedent Ever in I | U,S. 13. V | Was Decedent of I | Hispanic Originan, Mexican | n? (Spe | city Yas or No | - 14. Rac | ce - Amarican I | ndian, | |
| Examin | | 1 Navar Married 2 Mar 3 Widowed 4 ∰ Divorced | rried 1 Ta | s 2 No | | I □ Yes 2 No | | , 44.107 | nount, oto.) | Specif | | te | |
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| 4 | S | 12 | Ø | Ø Bookkeeper | | | Taracasa and an analysis | | | Accounting | | | |
| event, | Be | | 7. Father's Nama (First, Middla, Last) | | | | • | | | me (First, Middle, Malden Surname) | | | |
| aumatic e | 2 | William Reid | | | | | | | rginia Barry | | | | |
| . 3 | | 19a. Informant's Name/Relations | | 1. | | g Address (Stree | | | | | | da) | |
| | - | Elizabeth Lew 20a. Method of Disposition | is / Dau | | | Whiskey sition (Neme of | Kun, I | Laur | Date | | - City or Town, | State | |
| Important: If Nem 2 any injury or other ance. | | 1 ☑ Burial 2 ☐ Cremation | | m State | cemetery, cren | natory or other ple | | 1. | | | | | |
| ng n | 1 | 4 Donation 5 Other (5 | | et. Lincoln Gemetery 4 | | | 4/24/99 Brentwood, Maryl | | | ryrand | | | |
| anyi | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Mar shock, or hear failure. List only one cause on each line. | | | | | | | | | | | |
| delah | | | t only one cause or | each line. | ith. Do not ente | er the mode of dyi | ing, such es ce | ardiac o | respiretory er | rrest, | Apj Inte On | proximate erval Between set and Deeth | |
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State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death | Reg. | 44 | 3486 | | |
|--|---|---|---|---|--|--|
| Physician /Modisal | | 2. Dete of Death | Day 1999 | 3. Time of Death 5:48 AM | | |
| /Medica Examiner | to Facility Name (Mant Institution also street as described) | | 4c. County of Death Baltimo | re | | |
| Funeral Director | 5. Social Security Number 220-05-3164 6. Sex 12 M 2 F 7. Age (In yrs. last birthdey) 77 Yrs. Hours Min. | 8. Date of Birth (Month, Dey, Ye Sept. 4, | Date of Birth (Month, Dey, Year) 9. Birthplace (S Country) ept. 4,1921 Marylan | | | |
| death with the Maryland with the Maryland sens 23e or 23e-f show in must be notified at theirs! Director | Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location | | 1 | 10d. fnsida City Limits 1 ☐ Yes 2€No | | |
| | | | Citizen of What Cour | | | |
| _ 3 #5 7 | WYON China Tarana 1 1 Year 2 1 No. Consider | pecify Yes or No- Pican, etc.) | 14. Race - Americ Black, White, Specify: | | | |
| 1 21215-0020 ad within 72 hours at splene. we than "natural", or f, the Medical Exem Commission by 8 | | king 16b | b. Kind of Business/In | | | |
| | | ne (First, Middle, Maid | Steel Industry Middle, Maiden Sumame) | | | |
| Viand | | Anna Flor | | | | |
| Maryland nd 2 should be fla shih and Mental Hy 27 is marked oth r traumatic event | 19a. Informent's Neme/Reletionship (Type, Print) Catherine E. Feger/Sister 19b. Meiling Address (Street and Number or Ru. 7517 Iroquois Ave. E | | | 21219 | | |
| Baltimore, semit. Pages 1 a bepartment of Hea montant: If them my injury or othe most. | 20e. Mathod of Disposition 1 Buriel 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemelery, crematory or other place) Gardens of Faith Cem. 4/2 | | Location - City or To altimore, | | | |
| Dang permit. Departr importu any inji | 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral 7922 Wise Ave. Du | | | nc. 1222 | | |
| Confice be executed ding physician and ding physician and se as the bunk-transit and the physician and se as the bunk-transit and the physician and se as the bunk-transit and the physician and | | do'a | \$ | | | |
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| cords, P.O. BOX vequies that the death cer been signed by the attendin should be detached for use leted by Physician/N | Part II. Other eignifficant conditions contributing to death but not resulting in the underlying ceuse given in Part f. H. Hal sequelage factors | | | o the cause of death? bably 420nknown | | |
| D PS M Ch | Aordic insufficience | 24a. Wes an ai performed | 17 ev | ere autopsy findings reliable prior to impletion of cause death? | | |
| Vital Ke- sicien: The lav certificate has irector, page 2 Be-Comp | Congestive heart facture. | 1 ☐ Yes 2 No 1 ☐ Yes | | | | |
| Physician: ribis certific and director. | 25. Was case/referred to medical examiner 20. Place of Dea 4. Nursing H. 1. Inpatient 2. FR/Outpatient 3. DOA 5. Place of Dea 6. Place of Dea 6. Place of Dea 6. Place of Dea 7. Place of Dea | th (Check only one) | | | | |
| To the Hospital or Attending Physician: The is within 24 hours after death. To the Fureral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com | 1 Yes 2 No | g Home 5 A Residence 6 □ Other (Specify) 28d. Describe how injury occurred | | | | |
| LIVISION C tall or Attending P is after death. Is Director: After t ted in by the funera Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be datermined 28a. Plece of Injury - At home, ferm, street, fectory, office building, afc. (Specify) | | 8f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert | 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end place, 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occur and manner stated. | end dua to the cause rred et the time, date | e(s) and mannar as s end plece, end dua t | stated. o the ceusa(s) | | |
| To the trop of the | 29b. Signature and title of certifier Loseph DiAndond Lub D 22409 | 29d. | Date signed (Month, 4/21/89 | Day, Year) | | |
| 10 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loseph D'Antonio Lin M.D. 748 (05 Cor Drive Suete 20) | Theson | n, Md. | 21204 | | |
| State Registrar | 31. Daté filed (Month, Dey Year) 32. Registrer Signeture S. Sports | | / | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Daeth 3. Time of Deeth 1. Decedant'e Name (First, Middle, Last) **Physician** KAY APRIL WALTER FAIRALL 1999 3:51 AN /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE CENTER HARBOR HOSPITAL If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 12 M 2 F Months Deys 212 09 8499 80 Yrs. Aug. 21, 1918 Director Maryland Usual Rasidance of Decedant the Maryland 10c. City, Town or Location 10d Inside City Limits 10b. County 7 ie marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examinar must be notif ed all 1 ☐ Yas 2 No Anne Arundel Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 21225 5003 Brookwood Road U.S. Funeral 12. Was Decedent Evar in U,S. Amed Forcas? 1-15 Yas 2 □ No If Yas, Giva Year or Datas: W • W • II 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Merital Status Black, Whita, atc 1 Naver Married 2 Married 1 Yas 2 No Specify: Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Inspection Supervisor Koppers Piston Rings 12th 3 years 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Nema (First, Middle, Last) Mattie Phelps Walter Fairall 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Doris Fairall / wife 5003 Brookwood Road Baltimore, Maryland 21225 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 25 Burial 2 Cramation 3 Removel from Stete 4/24/99 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Facility 21. Signatura of Funaral Sarvice Licensea Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 remeroushy Part1. Enter the disease, o supplications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. Littory one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final FAILTURF DRGAN I WO WEEKS disaasa or condition rasulting in daath) Examiner Due to (or as a consequance of): SEPSIS Examiner TWO WEEKS physician and the bunal-transit Sequantially list conditions, if eny, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Lest Due to (or es a consequenca of): Physician/Medical Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Winknown (ORONARY ARTERY DISEASE à CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Ware autopsy findings aveilable prior to complation of cause of daath? 24a. Was an autopsy Completed SIGMOID COLON OF CARCINOM A 2 2 No 1 ☐ Yes 20 No 1 □ Yas 25. Was cesa rafarred to medicel examinar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Yas 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident after death Director: Could not be detarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Spacify) ŏ Mospital of 24 hours a Funeral D 29a. Cartifiar (Check only one) Certifying Physicien: To the best of my knowledga, daath occurred et the time, dete end piece, and dua to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. Medical To the Vithin 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar Archone & Shramoler RES OU O APRIL 1999 30. Neme and addrass of person who complated causa of death (Itam 23a) (Type, Print) ARCHANAK SHYAHSUNDER, 3001 SOUTH HANOUER STREET, BALTIMORE, MARYLAND 31. Data filed (Month, Day, Year) APR 2 6 1999 62. Registrar's Signature

Registrar



AR PERSONAL and the second work of the second sec

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

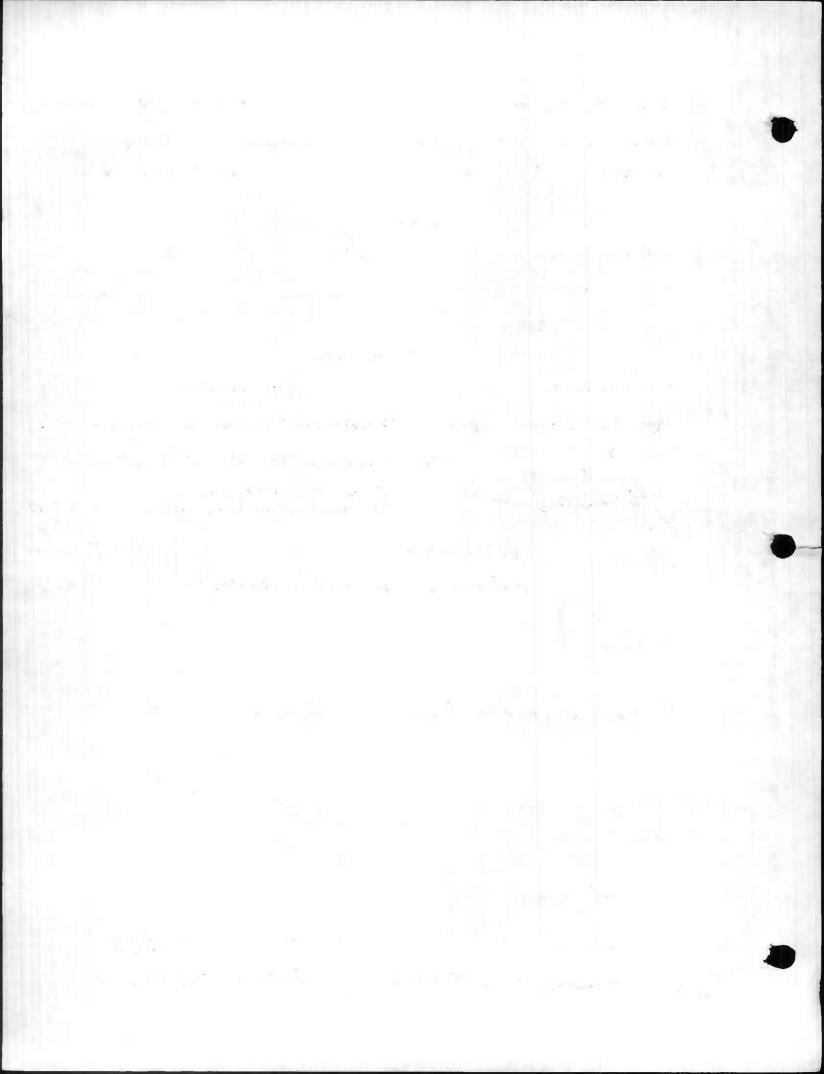
| | | Certificate of | Death | | g. No. | | | | |
|--|-------------------------------------|--|---|---|-----------------------|--|--|--|--|
| David John Gardner | 2. Date of Deat Month April 1 | Day Ye | 3. Time of Death 11:37 a.m. | | | | | | |
| a Facility Name (If not Institution, give street and r | number) | | 4b. City, Town, or L | | 4c. County of I | | | | |
| Hebrew Home of Greater | r Washington | | Rockvill | | Montgo | | | | |
| Social Security Number 110-26-5841 6. Sex | 7. Age (In yrs. last birti | hday) if Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, March 20 | Year) 6,1936 | Birthplece (State or Foreign Country) New York | | | |
| Usual Residence of Decedent Oa. State 10b. County | 10c. City, Town | or Location | | | | 10d. inside City Limits | | | |
| MD Montgomery | | | | 1 Yes 2 No | | | | | |
| 0e. Street and Number | | 10f. Zip Code | | 11 | 0g. Citizen of Whe | t Country? | | | |
| 8109 Paisley Place | | 20854 | | | USA | | | | |
| Armed | | 13. Was Decedent of H tf Yes, apecify Cub | dispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | American Indian, White, etc. White | | | |
| | d) a (1-4or 5+) | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | during most of work d) | | 16b. Kind of Busin | ess/Industry | | | |
| 12 12 7. Father's Name (First, Middle, Last) | P | sychiatrist | 18. Mother's Nam | e (First. Middle A | Health Maiden Sumame) | | | | |
| Marion J. Gardner | | | | J. John: | | | | | |
| 9a. Informent's Name/Reletionship (Type, Print) | 19b. | Mailing Address (Street | | | | ite, Zip Code) | | | |
| Debra Gardner-Baasch/I | | 259 Fieldst | | | | | | | |
| 0a. Method of Disposition | 20b. Place of | Disposition (Name of v, cremetory or other pla | | | 20c. Location - City | | | | |
| 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from | m state | nore Washing | | 4/19 | Laurel, 1 | Maryland | | | |
| Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, f eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury hat Initiated events resulting in death) Last d. | Due to (or as a co | onsequence of): | n mate | stra | , | Year, | | | |
| Part II. Other significent conditions contributing to | death but not resulting in | the underlying ceuse give | ven in Part j. | 23b. Did tobacco use contribute to the cause of death | | | | | |
| Servine disord | en Park | inson's | dysage | 1 Y | es 2₽No 3 | Probably 4 Unknown | | | |
| 0 | | | | 24a. Was a perion | | 24b. Were autopsy findings evallable prior to completion of cause of death? | | | |
| | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2년 No | | | |
| 5. Wes case referred to medical examiner? | | | 26. Plece of Deel | h (Check only on | Θ) | | | | |
| | ☐ Inpatient 2 ☐ ER/Out | patient 3LI DUA | | | ence 6 Other (| | | | |
| 27. Menner of Death 1 Pratural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28c. Injury et Work? 1 28c. Injury et Wo | | | | | | | | | |
| 4 Homicide | | | | | | | | | |
| 29a. Certifier (Check only (Check only 2 Medical Exemtner; On the | | | | | | | | | |
| 29a. Certifier (Check only (Check only 2 Medical Exemtner; On the | besis of exemination and | | opinion, death occur | red at the time, d | | d due to the cause(s) | | | |

6

Re DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

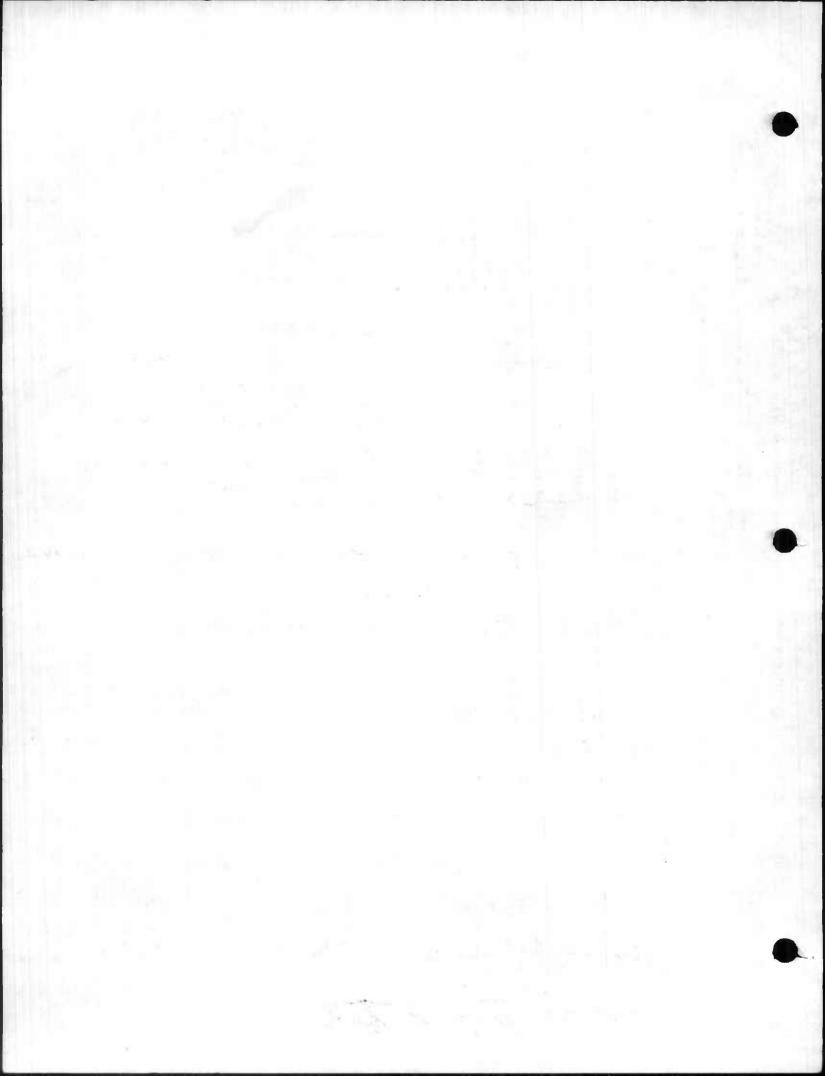
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | Otate of Mai | | Certifica | | | wichtai i i | Reg. No. | | 3489 | | |
|--|--|---|--------------------------|--|----------------------------|---|--|---|---------------------------|--|--|--|
| Physician /Medica | 1. Decedent's Name (First, Middle, Last) Gordon C. Hatt | | | | | | 2. Date of D Month | Peath Day | 7 9 9 | 3. Tima of Death 8:10 a m | | |
| Examine | 4a Facility Name (If not institution, giv | 1 1 11 | .5017 | 401 | | 4b. City, Town, or | Location of Dea | 1 | 1 1 | ounty | | |
| Funeral Director | 5. Social Security Number 6. 5 | ex 7. Age (| In yrs last birt | Months | Deys | | 8. Date of B | | 9 Birthn | lace (State or Foreign | | |
| P 3 | Usual Residence of Decedent 10a. State 10b. County | 11 | Oc. City, Town | or Location | | | | | 1 | 0d. Inside City Limits | | |
| with the Manyland a or 28a-f show the notified at | | | oc. oxy, rom | Glen B | urni | e | | | | 1 ☐ Yes 2 [] No | | |
| vith the Ma | 10e. Street and Number | | | 10f. Z | p Code | | | 10g. Citizen of | What Coun | try? | | |
| death w | 1425 Rowe Drive | 1 | | | 210 | | | Unite | | | | |
| 020 020 020 020 | 3 □ Widowed 4 □ Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Dec If Yes, sp | | dispanic Origin? (S an, Mexican, Puerl Specify: | ipecify Yes or N to Rican, etc.) | | ck, White, or White | etc. | | |
| 1 21215-0 ad within 72 ho yglene. Per than "neturn rt, the tradical rt. | 15. Decedent's El (Specify only highest gra Elementary/Secondary (0-12) | | 0.00 | life. DO NOT | use retired | pation during most of wo d) | rking | 16b. Kind of B | usiness/Inc | fustry | | |
| d 2 | 17. Father's Name (First, Middle, Last, | 2 | F | irefigh | ter | 18. Mother's Ner | me (First, Middl | A.A. C | | Governmen | | |
| = 0500 H | | | | | | | e Joyne: | | | | | |
| aryid s should and Men marks surrado | 19a. Informant's Name/Relationship (| Type, Print) | 196. | Meiling Addre | s (Street | and Number or Ri | | | State, Zip | Code) | | |
| W Super | Bonnie Hatt/Wife | | | 425 Row | | ive Gle | n Burni | | 1061 | | | |
| Baitimore | 20a. Method of Disposition 12 Burial 2 Cremetion 3 4 Donation 5 Other (Specif | Removel from State | cemeter | Disposition (No. y, crematory or Hill Ce | other plac | rv I | il 27, 1999 | 20c. Location Brookly | | | | |
| Baitimo permit. Pagei Deperment of Important: If it eny injury or page. | 21. Signature of Euclinal Service Licer | esee \ | | Kirk1e | y-RU | ss of Fecility ddick Fur Hwy. S.E | | | מת מו | 061 | | |
| Physician /Medical Examiner | 23a. Pert1. Enter the disease, or com shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death) | . Live | n n | | asi | | c or respiretory | errest, | | Approximate Interval Between Onset end Death | | |
| Box 68760, eeth certificate be executed ettending physician and I for use as the burial-transit | Cause (Disease or injury that initiated events resulting in death) Last | · Rospi | to loras e o | consequence of onsequence of | | en Co | phlu | igiali | | may | | |
| O dest | Part II. Other significant conditions of | ontributing to death but n | not resulting in | the underlying | cause giv | ven in Pert I. | 23b. Di | tobacco use co | entribute to | the cause of death? | | |
| cords, P.O. Box requires that the death cert been signed by the ettendin ehould be detached for use | Diahetes mellilies Hypatensian | | | | | | | 1 No 3 Probably 4 | | | | |
| Record law require hes been sig | Hypa Ceno | | | | | s an autopsy formed? | av: | ere autopsy findings silable prior to mpletion of cause death? | | | | |
| H the standard of the standard | Mahid | onen La | | | | | 10 | Yes 2000 | 10 | Yes 2 No | | |
| f Vitai Recystolen: The law securificate has director, page 2 | 25. Was case referred to medical examiner? | Hospital: | | | 0 | 26. Place of De | ath (Check only | one) | | | | |
| O Ph O Ph O Ph O Ph O Ph O Ph O Ph O Ph | 27. Manner of Death 1 Natural 5 Pending 20 Accident Investigation | 28a. Date of Injury (Month, Day Y | 2 ER/Out (sar) 28b. T | | 28c. Injur Wor | 4 LI Nursing F | _ | sidence 6 Ott how injury occur | | 0 | | |
| Division Of To the Hospital or Attending Phy Within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Dip he Hospital or no 24 hours effe he Funded Dir pletely filled in pedical Cert | 29a. Certifier 10 Certifying Ph (Check only one) | ysician: To the best of m liner: On the basis of ex and manner stated | amination and | death occurre Vor investigatio | l at the tir n, in my o | ne, date end place pinion, deeth occu | e, end due to the urred et the time | e cause(s) and m b, date and place, | anner es si and due to | ated. the cause(s) | | |
| To the comple | 29b. Signature and title of certifier | 1 . 1 . 1 | | 25 | | e number | | 29d. Dete signe | d (Month, | Day, Year) | | |
| | 30. Name and address of person who | Medaly completed cause of deat | | Type, Print) | DE | 30568 | | 4.23 | 5.49 | | | |
| | Shobha Reddy M.D | 1 1 | | ive Gl | en B | urnie, M | D 2106 | 1 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 2 6 1999 | 32.7 Highwards | Signature | To | 2 | | | | | | | |

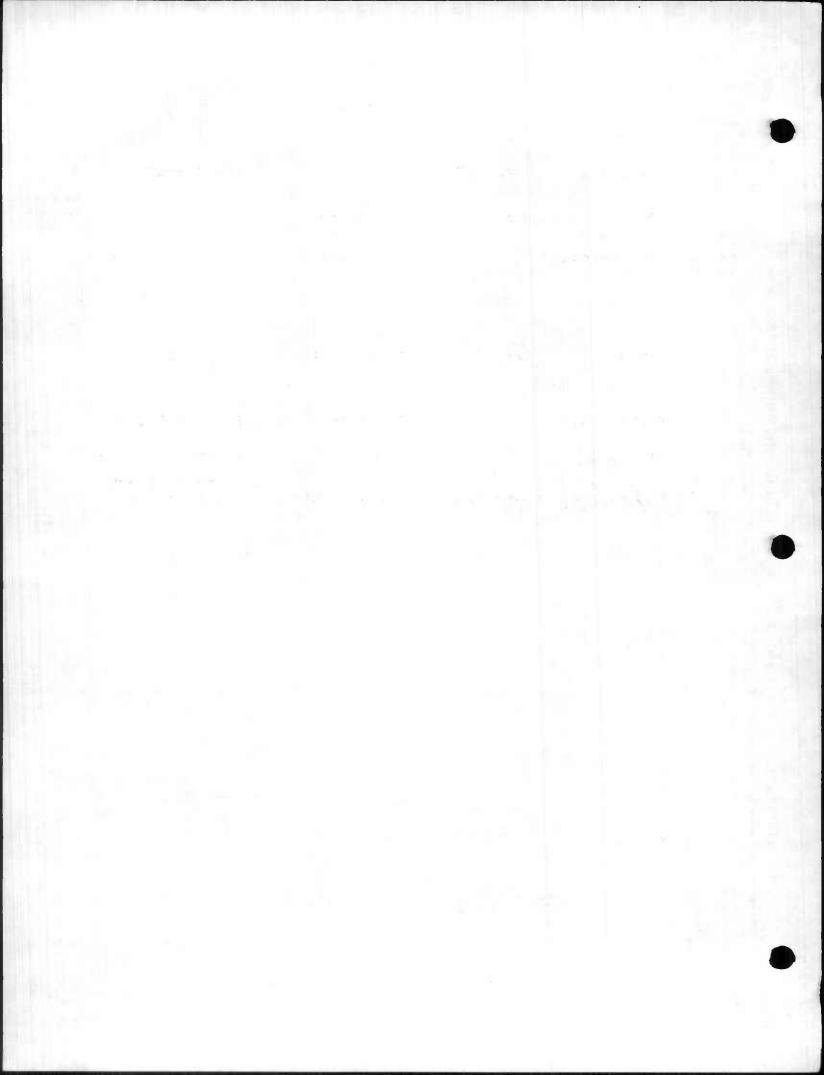


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician HOLMES. MINNIE 1999 3:00 PM APRIL 25 /Medical 4b. City, Town, or Location of Death 4s Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner Paper IMERE 6000 SAMARITAN HOSPITAL N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 2, 1900 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 25 F 98 Yrs. SC Director 215-12-2776 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Haaith and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumstic event, the Medical Examiner must be notified at edge. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD N/A BALTO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1356 Crofton Rd 21239 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes ¾ No Specify: BLACK þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 7TH N/A Housekeeper HOspital 18. Mother's Name (First, Middle, Malden Sumame) 17. Fether's Name (First, Middle, Last) Be Dundee Adams Frances Higgins 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Helen James 1356 Crofton Rd Balto, Md 21239 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Pk 4-29-99 Balto, Md 22. Name and Address of Fecility Betts Funeral HOme 21. Signeture of Fuperal Service Licenses 1129 N. CAroline St Balto, alla 23a. Part¹. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 DAYS. SEPSIS. Examiner Due to (or as a consequence of): Examiner PNEUMONA physician end s the burial-transit The law requires that the death certificate be axecuted Due to (or as a consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) ettending pl 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? should t 24a. Was an autopsy performed? Completed certificata has b firector, page 2 s 1 Yes 2 No 1 Yes ₺ No al or Attending Physician: T s after death. I Director: After this certificat ad in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1□ Yes 8 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours after to Funeral Direct inletaly filled in b 4 Homicide Hospital LE Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai To the Hosp within 24 hou To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number P- 12562 APRIL 25, 1999 Acuahindra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN HOSPIZAL, SAUTINUENE Anvo K MATTINDER , 400D 31. Date filed (Month, Day, Year) 32. Registrer's Signature APR 26 1999 Registrar

BHA



2 10 Yamilton

1. Decedent's Name (First, Middle, Last)

Franklin

212-30-1092 Usual Residence of Decedent

10e. Street and Number

11 Marital Status

916 Andrews Road

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12)

8

29b. Signature and title of bentile

Ivah

31. Date filed (Month, Day, Year)

17. Father's Name (First, Middle, Last)

Charles

19a. Informant's Name/Relationship (Type, Print)

10a State

5. Social Security Number

Catherine

10b. County

Maryland Anne Arundel

4a Facility Neme (If not institution, give street and number)

Square

15. Decedent's Education (Specify only highest grade complated)

6 Sex

1□ M 2□ F

Mary

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes = 2X No If Yes, Give Year or Dates:

College (1-4or 5+)

Siedenzahl

Mospital

80

Physician

/Medical

Examiner

Funeral

Director

must be notified at

7 is marked other than "natural", or items traumatic avant, the Modical Examiner m

Directo

Funerai

þ

Completed

Be

the Meryland

Pages 1 and 2 should be filed within 72 hours efter death with nent of Health and Mental Hygiena. nt of Health a If item 27 is or other tra 58 Stoneway Place Baltimore, Maryland 21236 Diane K. Hamilton (daughter) 20b. Placa of Disposition (Name of cemetery, cremetory or other place)
Sacred Heart of Jesus 4/24/1999 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home PA 21. Signature of Foneral Service Licensee 1407 Old eastern Avenue Essex, Maryland 21221 23a. Part . Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, that k, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) **Examiner** Examiner Hear Congestive Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) The law requires that the deeth certificate be axex Division of Vital Records, P.O. Box 68760; Myocardial Physician/Medical the Due to (or as a consequence of): attending pl Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an autopsy s certificata has b 1 Yes 2 No Hospital or Attanding Physician: director, 25. Was case referred to medical Be 28. Plece of Deeth (Check only one) Hospital: 1 Ø Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No After this the funeral 27, Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil (Check only

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Borrello

> > APR 2 6 1999

9000

32. Registrar's signeture

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Hamilton

Housewife

7. Age (In yrs. last birthday) If Under 1 Year Months Days

10c. City, Town or Location

Glen Burnie

Center

10f, Zip Code

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

29c. License number

Jauare

Drive

franklin

21061

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2. Date of Death

Month

Apr.1

4b. City, Town, or Location of Death

Margaret

G.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 3. Time of Death Year 9:15 PM 4c. County of Death Rosed le Raltimore
If Under 24 Hrs.
Hours Min.

B. Date of Birth
(Month, Dey, Year)

April 30,1918

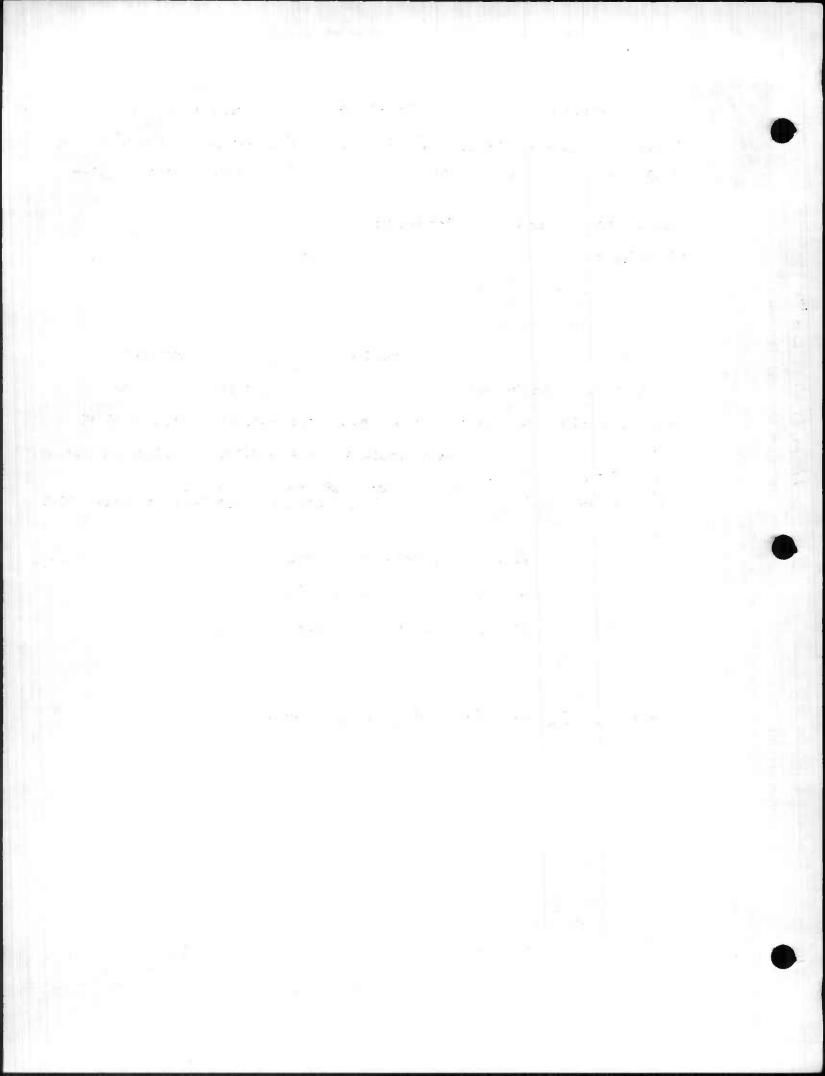
Maryland Baltimore Birthplace (Stata or Foraign Country) 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maldan Sumama) Lang 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Baltimore, Maryland Approximate interval Between Onset and Death 10 days 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

21 manyland

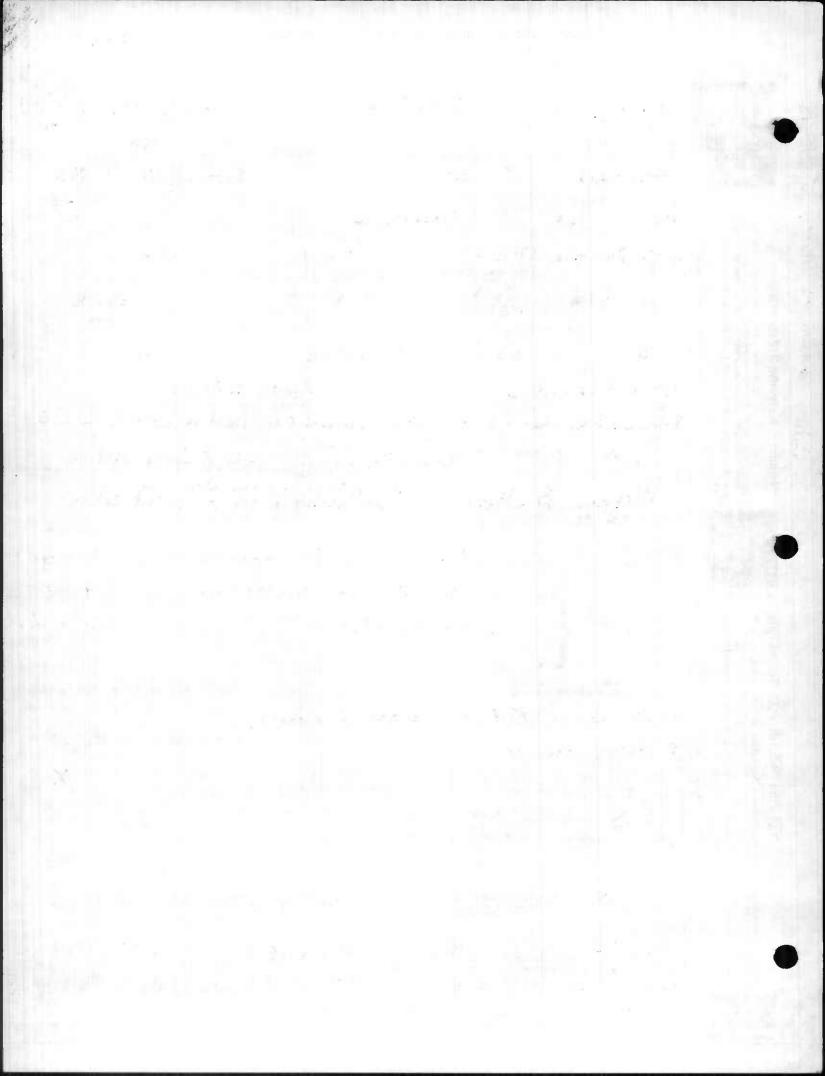
Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 6:45 AM **Physician** JANE HARRIS 22 MARU /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NA Baltimor Baltimore of Hospital If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2 W Yrs. Sept. 6, 1947 Director 219-44-9233 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or frams 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1 XYes 2 No MD NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1609 Balmor 21217 AZU Court 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Black py 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) outient Known permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiena. Important: If Nem 27 is marked other than Elementary/Secondary (0-12) Coilege (1-4or 5+) NA Disabled 9+4 NA 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) BROWN Harriday ANNa John 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Baltimore Md 2920 Viman Ave. James J. Marshall - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4.26.99 Balto Md ME + RO CREMATORY 21. Signature of Funerel Servica Licansee 22. Neme end Address of Facility March Funeral Home West, The 4300 Wabash Aug. Batto Lid. tamo 21215 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Candida Examiner Due to (or es e consequence of): Examiner Bacteremia weeks Aureus physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequença of): certificata be axe Osteomyolitis weele Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown Circhosis Failure signed t h 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Diabetes Mellitus 1 ☐ Yes 2 No Yes 2 No I or Attending Physician: aftar deeth. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours Hospital edicai 29a. Certifler Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end manner stated. To the within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signature endrtitle of cartifier 29c. License number e end address of person who completed cause of deeth (Item 23e) (Type, Print) W. Delvedere prime Baltond Barnard Kathryn G. 31. Dete filed (Month, Dey, Year) APR 2 6 1999 32. Registrer's Signeture State Registrar



Baltimore, Maryland 21215-0020

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiens. Important: If fem 27 is marked other than "natural", or items 22s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as

Physician

/Medical Examiner To Be Completed by Funeral Director

| | Chain of Man | | | | k. Assure A | - | | _ | Dic. | | |
|---|--|--|---------------------------------|--|----------------------------------|---|--|---------------|--|--|--|
| | State of Ma | | | rtment of cificate of | Health and Death | Mental | Hygie Reg. | 0.0 | 9 13493 | | |
| 1. Decedent's Neme (First, Middle, La | ist) | | | | | 2. Date of Month | of Death | Day | 3. Time of Deeth | | |
| John Harold Ho | | | | | 4b. City, Town, or | Apri | 1 22, | | 999 8:30 AM | | |
| | Chicago and Chicago | | | | | LOUBLING | Deau | | | | |
| Stella Maris 1 5. Social Security Number 6.5 | • | Ter (In yrs. last birth | Adevi | If Under 1 Yea | Towson | | od Birth | | ltimore 9. Birthplace (State or Foreign | | |
| 227 04 7000 | Sex XXM 2□ F | Contract of the Contract of th | | Months Day | | n. (Mont) | 1, 19 | 953 | Country) Virginia | | |
| Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Loca | ation | | | | | 10d. Inside City Limits | | |
| MD Prince | | Laur | _ | | | | | | 1 ☐ Yes 2 No | | |
| 10e. Street and Number | 300282 | | | 10f. Zip Code | | | 100 | Citizen of | What Country? | | |
| 15901 Bond Mill | Read | | 7-4 | 2070 | | | | USA | What Gooding . | | |
| 15901 Bond MIII . | 12. Wes Decedent Ev | iver in U.S. | 13. We | es Decedent of | of Hispanic Origin? (S | Snacity Yes | or No- | - | ce - American Indian, | | |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | If Y | Yes, specify Cu | Suban, Mexican, Puer | to Rican, etc | 2.) | Bled | white | | |
| 15. Decedent's E | | 16a. / | Decader | int's Usuat Occ | cupation | | 16 | h Kind of B | Business/Industry | | |
| (Specify only highest gra | rade completed) | | (Give kin | ind of work don O NOT use reti | ne during most of wo | rking | | J. Tuniu | adition induction, | | |
| Elementery/Secondery (0-12) | College (1-4or 5+) | +) | | ery Dri | | | 1 | Cosmet | tics | | |
| 17. Father's Neme (First, Middle, Last, | 0 | | | | 18. Mother's Na | ime (First, M | liddle, Mai | iden Sumen | me) | | |
| John Harold Ho | rton, Sr. | | | | Hazel | Taylo | r | | | | |
| 19e. Informent's Neme/Reletionship (| (Type, Print) | 19b. | Mailing | Address (Stre | eet and Number or Ru | lural Route I | Number, C | Lity or Town, | , State, Zip Code) | | |
| Lue Anne Horton/ | Wife | 159 | 901 | Bond M | ill Road, | Laure | 1. M | aryla | nd. 20707 | | |
| 20a. Method of Disposition **XXBuriel 2 Cremation 3 C 4 Donetion 5 Other (Specification) | ify) | 20b. Place of E | Dispositi y, cremet ridge | tion (Name of story or other p e Memor | place) rial Pk | Date 4-26-9 | 99 E | c. Location - | -City or Town, Stella ge, Maryland | | |
| 21. Signeture of Juneral Service Licer | Will _ | | | | | | | | me, Inc. Maryland, 20707 | | |
| 23a. Pert1. Enter the disease, or com shock of heert feilure. List only | plications that caused to one cause on each line | he death. Do no | ot enter t | the mode of d | ying, such as cardia | c or respiret | ory errest | | Approximete Interval Between Onset and Death | | |
| Immediate Ceuse (Final disease or condition resulting in death) | a | TIC CANO | | ence of): | | | | - | | | |
| Sequentially list conditions, | b | Due to (or as a co | onseque | ence of): | | | | | | | |
| if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events | с | C | | | | | | | | | |
| resulting In death) Last | d | | | | | | | | | | |
| Pert II. Other aignificant conditions o | ontributing to death but | not resulting in f | the unde | erlying cause | given in Pert I. | 23b. | | acco use co | ontribute to the cause of death? | | |
| | | | 4.50 | | . Was an a | | 24b. Were autopsy findings available prior to completion of cause of deeth? | | | | |
| | | | | | | | 1 Yes | 2 X No | 1 □ Yes 2 No | | |
| 25. Was case referred to medical examiner? | | | | | 26. Place of De | sath (Check | only one) | | | | |
| 1 ☐ Yes 2 🕱 No | Hospital: 1 Inpatient | | | 3LI DON | | T | | | ther (Specify) HOSPICE | | |
| 27. Manner of Death 1 2 Neturel 5 Pending 2 Accident investigation | | Year) 28b. Tir | ima of njury | 28c. In W | njury at Nork? I Yes 2 No | 28d. Desc | 28d. Describe how injury occurred | | | | |
| 3 Sulcide 6 Could not b determined | | y - At home, fem (Specify) | m, street | t, fectory, offic | ю | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |

To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Dete filed (Month, Dey, Year)

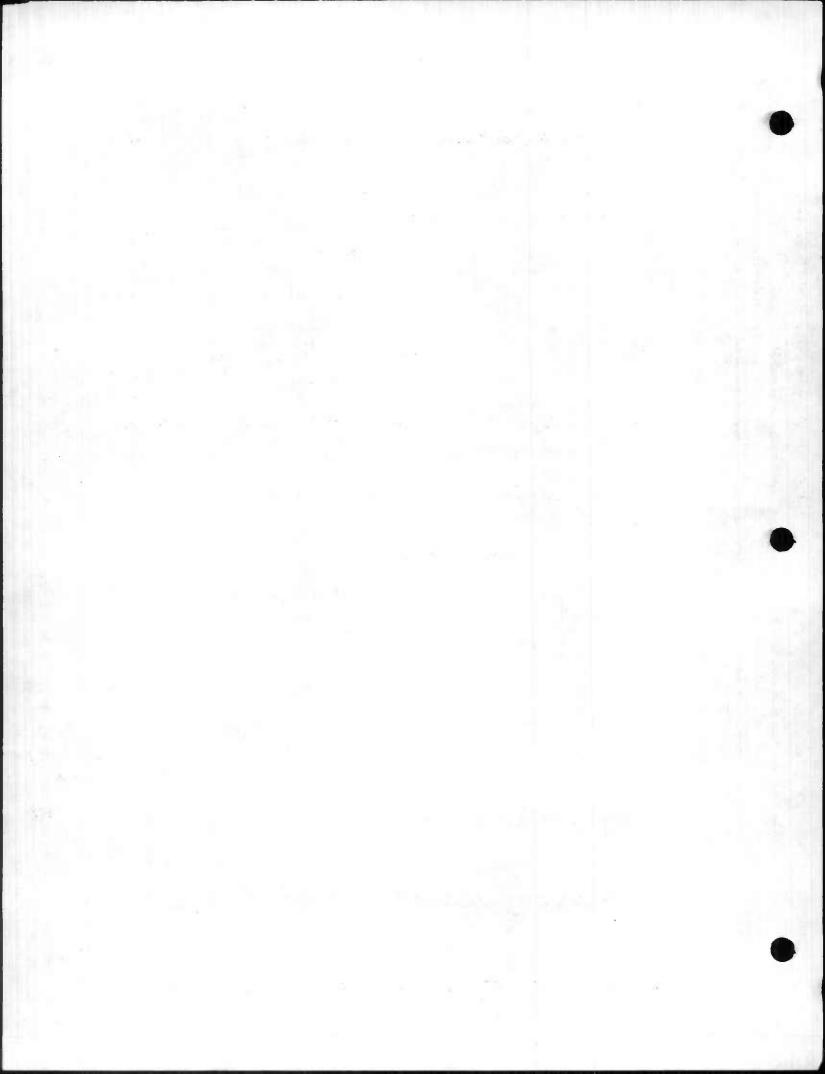
29b. Signature and little of certifier

32. Registrar's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Dey, Year)



Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other treumstic event, the Medical Examinat must be not the market.

Examiner physician end the buriel-transit The law requires that the death certificate be executed for use as ed by the e bengis be del peen page 2 certificate Hospital or Attending Physician: director, this

Physician/Medical by Completed Be

1 Naturel 2 Accident 3 Suicide 4 Homicide

Certification: To After this death. offer death.

Director: A

Division of Vital Records, P.O. Box 68760,

State Registrar

edical

29e. Certifier (Check only one)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Johns Hopkins Hospital Baltimon, Mo

The

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1 ☐ Yes 2 ☐ No

D45068

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Dey, Year)

April 22, 1999

31. Dete filed (Month, Day, Year) APR 26 1999

30. Name and address of person

29b. Signetura and filts of certifier

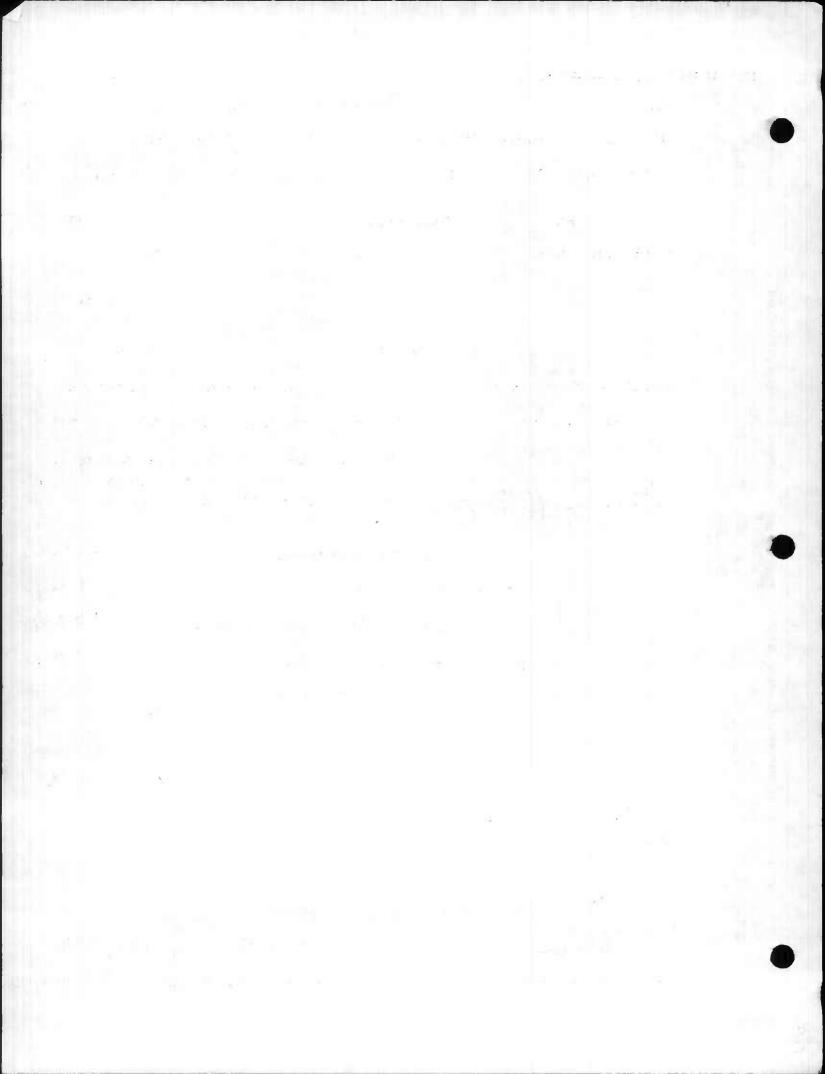
5 Pending

Investigation

6 Could not be determined

DHMH 16 Rev 6/95

To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b



Funeral

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Maryland

d 2 should be filed within 72 hours after deeth with the Marylan th and Mentel Hygiene.
7 Is marked other than "naturel", or items 23s or 28s-f show traumetic event, or Medical Exercited Francisco.

permit. Peges 1 end 2 sh Department of Health and Important: if Item 27 Is rr any Injury or other traun pnce.

Physician /Medical

Examiner

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After this funeral

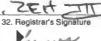
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Registrar

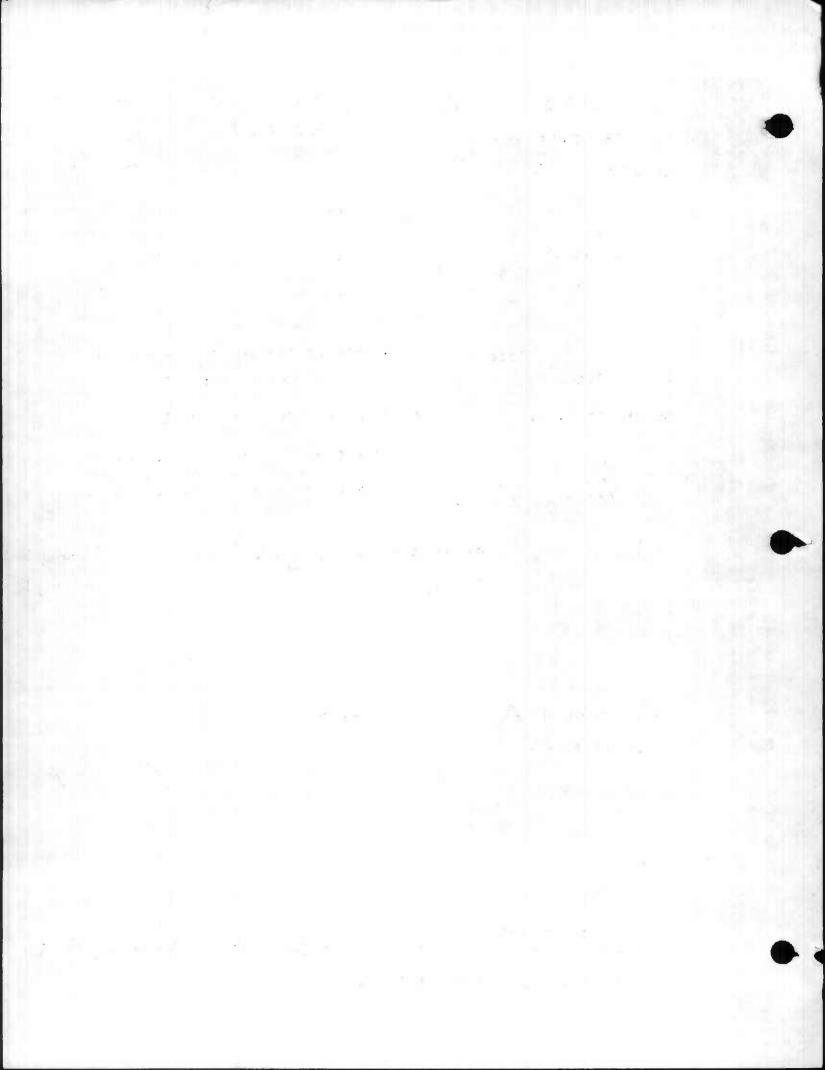
APR 26 1999

31. Date filed (Month, Day, Year)

HERBR BY



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 9 Certificate of Death Item#7 perFH G770 4/26/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Johnson Raymond 23:36 4b. City, Town, or Location of Deeth 1999 14 4a Facility Name (If not institution, give street end number) 4c. County of Death Rockville MD Shady Grove Adventist Hospital Montgome ry 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1X M 2□ F 5. Social Security Number Birthplace (State or Foreign Country) Yrs. 877-88 212-05-2130 Dec. 19, 1911 Maryland Usuel Residence of Deceden 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 W. Deer Park Road 20877 U.S.A. 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married Specify: white 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fireman Baltimore City 16. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Alonzo C. Johnson Florence M. Duvall 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Alma Johnson/wife 211 Russell Ave., #408, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Wada Ronald S. Director State Anatomy Board, 655 W. Baltimore St. Baltimore, Mayrland 21201

2011. Part 1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. leuce Approximate interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Due to (or es a consequence of) priniled om truct Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (as a consequence of) pancientitis Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy completion of ceuse of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (I) Impatient 2 ER/Outpatient 3 DOA 26d. Describe how injury occurred 27. Manner of Death 26b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

Box 68760. Division of Vital Records.

certificate be executed physicien and the buriel-trans 88 950 signed b page 2 s Hospital or Attending Physician: this funeral After efter death. 24 hours e To the Hosp within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Director

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner mant be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any injury or other traumatic event, the Wad call Exempt

Physician

/Medical **Examiner**

Examiner

Physician/Medical

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Completed

Be

P L

Baltimore, Maryland 21215-0020

with the Menyland

death

Certification: Medicai

revin 31. Date filed (Month, Dey, Year) APR 23 1999

frues. lun

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

(Check only one)

29b. Signeture end title of cartifier

15001 Shady 32. Redistrar's Signature

STOVE

29c. License number

D-30869

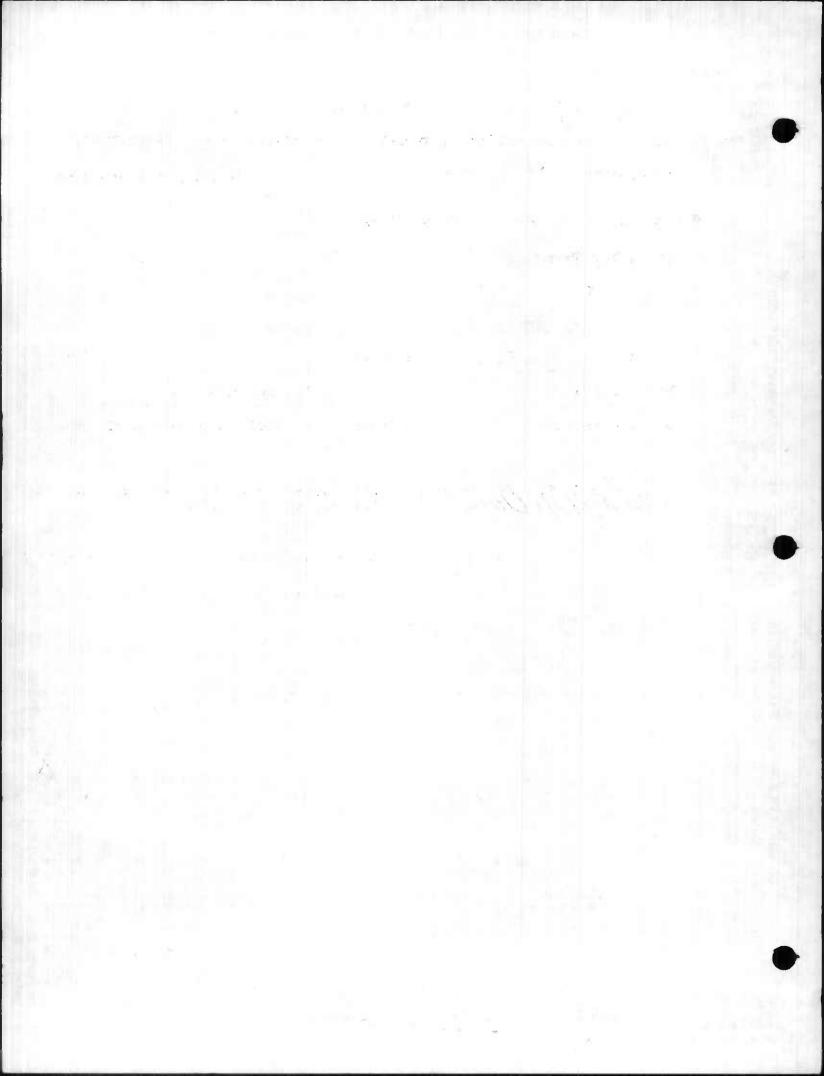
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29d. Date signed (Month, Dey, Year)

ROCIWILY Md. 20850

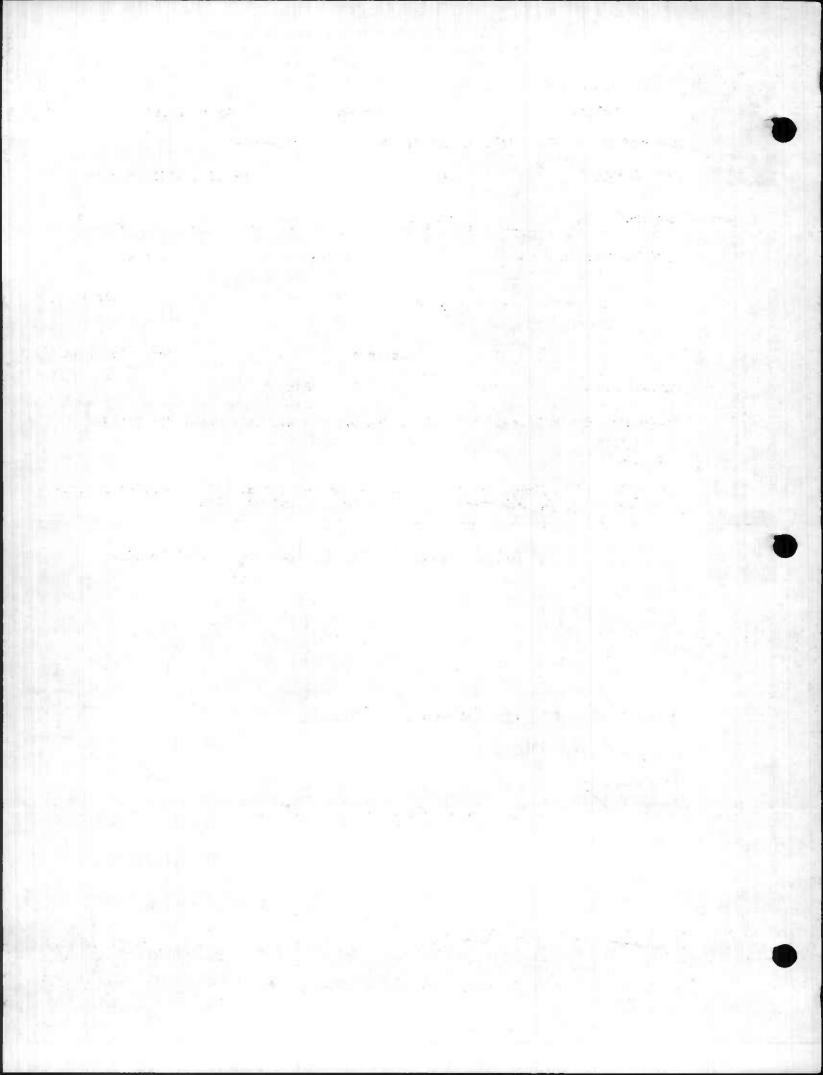
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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Na | me (First, Midd | dle, Last) | | | | | | | | ote of Deal | th Day | Yeer | 3. Time of Death | |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| sician edical | Walter | | | | | | Johnson | n | | | pril | 17.19 | | 9:15 A | |
| miner | 4e Fecility Neme | | | reet and num | nber) | | JUIIISU | | b. City, Town, | or Location | of Death | | ty of Deeth | | |
| | Homewood | Future | e Car | e 2700 | N. Ch | narles | St | | Balti | more | | na | 1 | | |
| al | 5. Sociei Security | Number | 6. Sex | | 7. Age (In yrs. | last birthdey, | Months | Year | If Under 24 H | in. 8. De | te of Birth | Year) | 9. Birth | plece (State or Forei | |
| r | 219-22- | 5038 | 1 (2), N | M 2□ F | 7 | 2 Yrs. | Wiorkins | Days | 110013 | | | 1926 | | land | |
| | Usual Residence | | | | 10- 0 | to Tour out | | | | | | | | | |
| - | 10a. Stete 10b. County | | y | | | ty, Town or L | | | | | | | | 10d. Inside City Limi ↓□ Yes 2□ N | |
| Funeral Director | Marylan | | | | ва | ltimor | | | | | | | | 31 | |
| Dire | 10e. Street and N | | | | | | 10f. Zip C | | | | 1 | 0g. Citizen of | | intry? | |
| <u>a</u> | 2700 N. | | | | | | | 121 | | | | U.S | | | |
| une | 11. Merital Stetus | | | Armed For | | J,S. 13. | If Yes, specif | fy Cuba | ispanic Origin? In, Mexican, Pu | (Specify Yuerto Rican | es or No- | | ack, White | ican Indien, , etc. | |
| by F | | rried 2 Mai | | 1 X Yes If Yes, Give | 2 No | 10 | 1 ☐ Yes 2 | D.No | Specify: | | | Spec | ify: b1 | ack | |
| D D | 3 - WIGOWEG | | | | tes: 1945 | 1 | edent's Usuel | Occupa | etion | | - | 16b. Kind of | Bustness/Ir | ndustry | |
| Completed | | 15. Deceder ecify only highe | est grede c | completed) | | (Give | kind of work | done d | during most of | working | | TOD. KING OF | 00311103311 | Istness/Industry | |
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| o Be | Walter | Green | | | | | | | Anna J | Iohnso | n | | | | |
| To | 19a. Informent's | | nship (Type | e. Print) | | 19b. Mail | ina Address (| (Street a | | | | r. City or Tow | n, State, Zi | ip Code) | |
| | Jacque1 | | | , | | | _ | | and Number or Rural Route Number Ave., Baltimor | | | | | | |
| | 20e. Method of Di | | | | 20b. | Place of Disp | osition (Name | e of | | Da | | 20c. Location | | | |
| | 1 🗆 Burial | 2 Cremation | | moval from S | State | cemetery, cre | emetory or oth | her plac | (8) | | | | | | |
| | 21. Signature of I | 5 Other (S | | - | | | 2. Name end | Addros | ne of Engility | | | | | | |
| | | Ronald | | | irctor | | | | | ard, | 555 W | . Balt | imore | Street | |
| important: if item 27 is marked other the eny injury or other treumatic event, the pace. To Be Com | Mani | 20A1 / | // // | 1/20 | | | | | | | | | | | |
| | 50 000 | 001 | 10 | Just . | | | | | Mary1 | | 21201 | - | | Anaroulmata | |
| | 3a. P. 1. Enter | r the disease, of eart failure. Lis | or complica st only one | ations that ca | aused the dea ech line. | | | | | | | est, | | Approximate Interval Between Onset and Deeth | |
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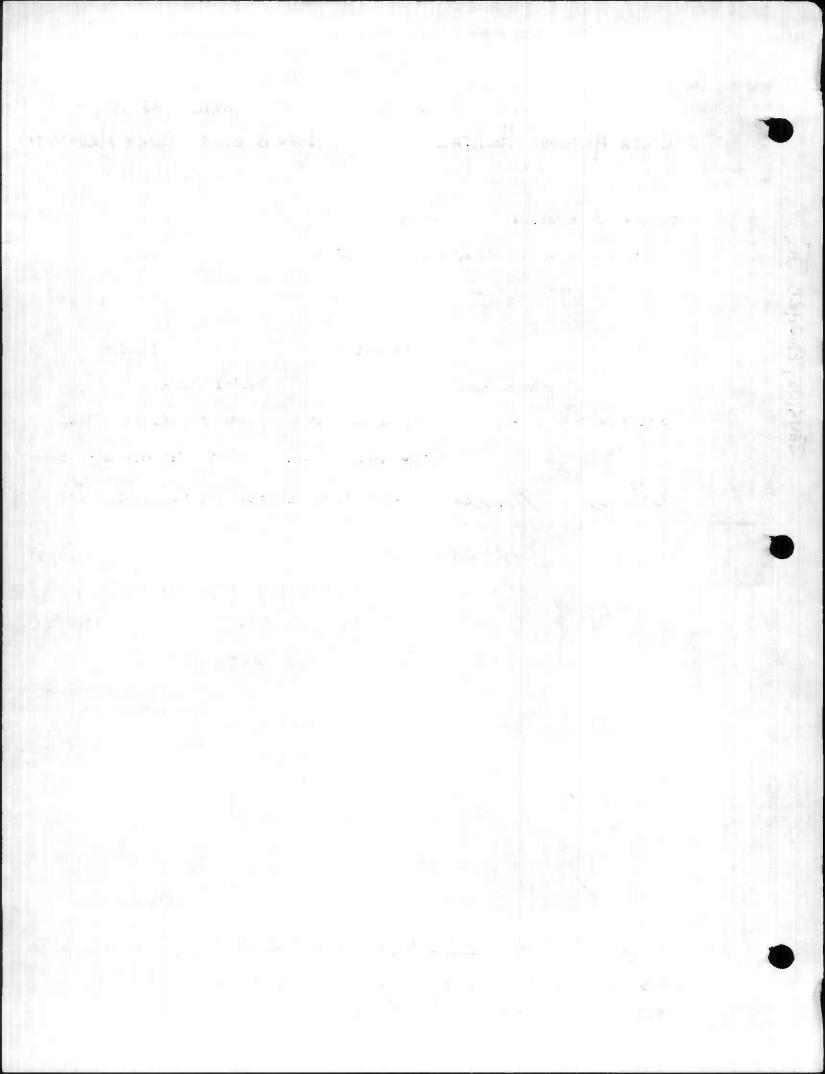
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Data of Death 3 Time of Death 1 Decedent's Name (First Middle Last) APRIL 1230 AG **Physician** Edward Jenkins Jr. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner RUNDEL HOSTITAL GLEN ANNE BURNIE RUNDEL NORTH If Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year, 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birtholaca (Stata or Foraign **Funeral** 1X0 M 2□ F 55 Yrs. 219 40 4875 21, 1943 Director Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 le merked other than "natural", or items 23s or 28s-f show traumatic event, the Mourcal Examiner must be motified at 1 Yes 2X No Anne Arundel Director Maryland Pasadena 10f. Zip Coda 10g. Citizan of What Country? 21122 688 Lake West Shore Road Apt. 8 U.S. Funerai 14. Race - American Indian, Black, White, afc. 12. Was Decedanf Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 11. Marifal Status 1 Yas 20 No If Yas, Giva Year or Datas: JENKINS, EDWARD 1 □ Navar Marriad 2 □ Married 1 Yas 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorcad 15. Decedant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16h. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Is marked other than Building Carpenter 10th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be Department of Health end Mental Important: If item 27 is marked 1 any injury or other traumatic ev page. Muriel Mitchell Edward Jenkins 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Pasadena, Maryland 21122 Rodney Jenkins 218 Chelsea Road 20b. Place of Disposition (Nama of cametary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burlal 2 X Cramation 3 ☐ Ramoval from Stata 4/26/99 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Othar (Spacify) Funaral Sarvice Licenses 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 Conc 23a. Part1. Entar thy diseas, of complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure, and only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) PANCALATITI(Examiner DISTNESS SYNDRAYE respINA TONY Examiner attanding physician end for use es the buriel-transit certificate be executed Sequantially llsf conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Box 68760. Physician/Medicai 98 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been s Tha law certificate has 1 Tyas 28 No 1 TYas or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 1 Impatiant 2 ER/Outpatient 3 DOA After this funerel 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Panding invastigation 1 Natural efter death. 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) filled in by 4 Homleida within 24 hours e 29a. Certifier edicai 12 Certifying Phyalclan: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and title of cedifie causa of daath (Itam 23a) (Type, Print) 30. Nama and addrass of person who co NONTH ANUNDER HOSPIFAZ Utalistener 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

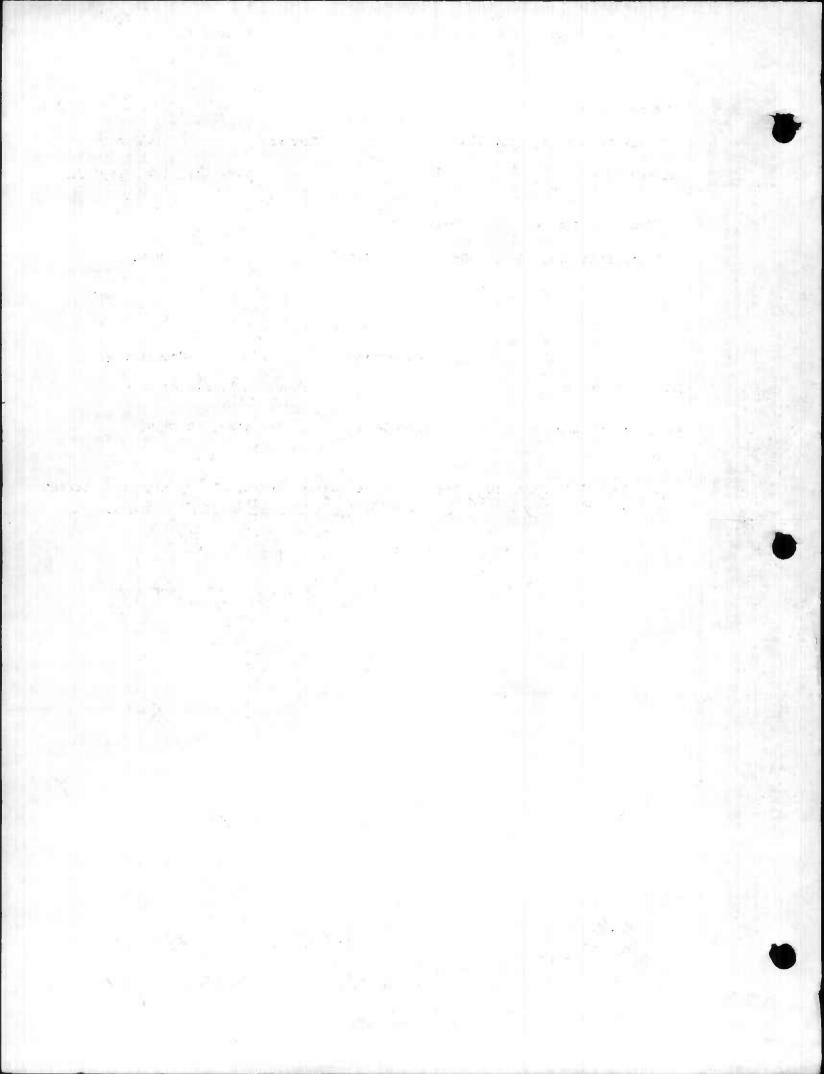
Registrar

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|--|---|---|--|---------------|--|---|------------------|----------------------------|---|---|-------------------------------|---------------------|--|--|
| S leveleter | | 1. Decedent's Name (First, Middle, Last) Evelyn Kinsella | | | | | | | | Month Dev Year | | | 3. Time of Deeth | |
| Physiciar /Medica | 1 | | | | | | | | 4b. City, Town, or Location of Do | | | - 13 - 1899 2 | | |
| Examine | r 48 | Facility Neme (If not institution, giv | | | | | 4 | _ | | ation of Deet | | | | |
| | 5 | 500 Virginia Ave Sociel Security Number 6.5 | | | lest birthdey) | If Under | 1 Yeer | Towos | | 8. Date of Bir | | timor | | |
| Funeral Director | | | □M 2\ F | | O Yrs. | Months | Deys | Hours | Min. | (Month, De | th ly, Year) 1918 | Mary | lece (Stete or Foreign try) Land | |
| D | | suel Residence of Decedent | | 1.0.01 | _ | | | | | | | | | |
| show of at | | 10e. Stete 10b. County 10c. City, Town or Location | | | | | | | | | | 1 | 0d. Inelde City Limits 1 ☐ Yes 2 ☐ No | |
| 28a-f | M M | Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code | | | | | | | | T | 10g. Citizen of What Country? | | | |
| With With | Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code | | | | | | | | | U.S | | , | | |
| deeth | 1 | 1. Marital Stetus | 12. Was Decede | nt Ever in U | .S. 13. | | ent of H | ispanic Orig | gin? (Spec | cify Yes or No | - 14. Ra | e - Americ | | |
| | | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Force 1 Yes 2 It Yes, Give Year or Dete | No | | 1 ☐ Yes 2 | - | | , Pueno r | ilceri, etc.) | Specif | ck, White, y: Wh | ite | |
| 72 ho | Completed by | 15. Decedent's Ed (Specify only highest gra | ducation ide completed) | | 16a. Dece (Give | dent's Usua kind of wor DO NOT us | l Occup | ation during most | of workin | g | 16b. Kind of B | usiness/In | dustry | |
| within ene. | ă - | Elementary/Secondary (0-12) | College (1-4 | or 5+) | | | |) | | | | | | |
| e filed vall Hygie other t | 8 | 8 7. Father's Name (First, Middle, Last, | | | | anacurist 18. Mother's Nam | | | r's Name | me (First, Middle, Maiden Sumeme | | | | |
| Mental Mental arkad o | m l | John R. Merrick | | | | | | Flo1 | rence | L. S1 | ackelfo | rd | | |
| 2 should be end Mental is marked of aumstic ev | 1 | 9e. Informant's Name/Relationship (| Type, Print) | | 19b. Malli | ng Address | (Street | e <i>nd N</i> um <i>be</i> | or or Rura | Route Numb | er, City or Town | , Stete, Zip | Code) | |
| and 2 is selfth or trau | J | Joseph Foley/neph | ew | | 2104 | Moren | iga (| Ct., I | Falls | ton, N | D 2104 | 7 | | |
| permit. Pages 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumetic event, the Monce. | 20 | De. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ② Donation 5 ☐ Other (Specif | Removel from Sta | 1 | Place of Dispo emetery, cre | osition (Nem | ne of | | | Date | 20c. Location | - City or To | own, State | |
| Departr Importu any inje | 2 | Ronald S, Wade Director State Anatomy Boar Baltimore, MD 212 | | | | | | | | rd, 655 W. Baltimore Street | | | | |
| | 2 | Part1. Enter the disease, or com- | plications that caus one cause on eecl | sed the deet | h. Do not en | ter the mod | e of dyin | g, such as | cardiec or | respiretory e | errest, | i | Approximete Interval Between Onset and Death | |
| sete be shysicia the bui | Examiner 35 | mmediate Cause (Final lisease or condition esulting in death) Gequentielly list conditions, eny, leading to immediate euse. Enter Underlying leuse (Disease or Injury net Initiated events esulting in deeth) Last | e. <u>Nu</u> b. <u>Co</u> c. | Due to (d | dia lor as a conserva es e conserva as e conserva es e con | quence ot): | 9 9 | Dise | ast | | | | | |
| es that the death certific igned by the attending p be deteched for use es | PhysiciaryMedical | and II. Other algorithms of conditions of | d | d | | | | | | 23b. Did tobacco usa contribute to the cause of dea | | | | |
| ed by the deteche | by Phys | arti, other agricult conditions | Ontributing to death | | | | | | | 1 Yes 2 No 3 Probably 4 U | | | | |
| law requires es been sign 2 should be | Completed | | | | | | | | | | an autopsy ormed? | ev | ere autopsy findings eilable prior to empletion of cause deeth? | |
| The law ete hes page 2 | E | | | | | | | | | 10 | Yes 2 No | 1[| Yes No | |
| certificate rector, pag | | 5. Wes cese referred to medicel examiner? | | | | | | 26. Place | ot Deeth | (Check only | one) | | - | |
| this ai di | 0 | 7. Menner ot Deeth 1 Natural 5 Pending | | | ER/Outpatie 28b. Time of Injury | ot 2 | 8c. Injur Wor | y et k? | | ome 5 Residence 6 Other (Specify) 28d. Pescribe how injury occurred | | | | |
| To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer | Certification: | Accident investigatio 3 Suicide 6 Could not be determined | | | | | | | 28t. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To the Hospital within 24 hours To the Funeral completely filled | | | nysictan: To the be niner: On the basis and menner | ot exemina | | | | | | | | | | |
| To the Fo the Somple | | 9b. Signeture and Mile constitution | | | | 290 | . Licens | e number | | | 29d. Days sign | (Month, | Day, Year) | |
| | |) H | - | | | 1 | 13 | 289 | 7 | | 4/191 | 99 | | |
| | 30 | O. Name and address of person who | 111 | ^ | n 23e) (Type, | Print) | ia- (| · · · S | St. | Balti | more, | MU | 2/2/8 | |
| | 0 | 1. Dete tiled (Month, Day, Year) | 4 32 Ren | strar's Signe | ature | | | | | | - | | | |



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| UR | | State of Maryland | Department of I | | | ene | 13500 |
|---|--|--|---|------------------|-----------------------------------|-------------------------|--|
| Physician Medical | 1. Decedent's Name (First, Middle, Last) ARTHUR KE | nt | | | 2. Date of Death Month |) | 3. Time of Death 13:29 PM |
| Examiner Funeral | 48 Facility Name (If not institution, give s BON SECOUR HOSPIT. 5. Social Security Number 6. Sex | AL | birthday) If Under 1 Year Months Days | | 8. Date of Birth | Year) | 9. Birthplace (State or Foreign |
| Director | Usual Residence of Decedent 10e. State 10b. County HARY and never | 10c. City, To | own or Location | | July 04,1 | 7735 1 | 10d. Inside City Limits 11XYes 2□No |
| flar death with the Mer remains 23e or 28e-fe should be proud a Funeral Director | 10e. Street and Number ///5 N. CARCY 11. Marital Stalus | Street 2. Was Decedent Ever in U.S. Armed Forces? | 10f. Zip Code 2 / 6 13. Was Decedent of If Yes, specify Cut | | | | |
| by | 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade | 1 Yes 2 M No If Yes, Give Y Year or Dates: | 1 ☐ Yes 2 No | Specify: | 11 | AMERICAN iness/Industry | |
| d within plene. r then re then | Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | ille. DO NOT use retire | ed) | e (First, Middle, N | Wert Taiden Sumame | terminal INC |
| ges 1 and 2 should t of Health and Man if Itam 27 is marks or other traumatic | 19a. Informant's Name/Relationship (Ty) HARY Kent - S 20a. Method of Disposition 1 Burial 2 Cremation 3 Re- | PCN SC / 20b. Place | 9b. Mailing Address (Stree | eey Stree | A BAH | City or Town, S | Angland 2121 |
| pemil. Pa Departmen Important: eny injury. once. | 4 Donation 5 Other (Specify) 21 Signature of Funeral Service License | Callace | 22. Name and Addr 3405 W, | FRANKI | way m. | WALLA BAHIA | awne HARy knd the FS noise, MARYKEL |
| Physician /Medical Examiner | 23a. Part 1. Enter the dise, or complications, or heart I mire. List only on Immediate Cause (Final disease or condition resulting in death) | Atheroscleret | | | | | Approximate Interval Between Onset and Death |
| ificete be executed giphysicien and as the burlei-fransit ledical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a consequence of): | | | | |
| ist the death certified by the attending etsched for use a Physician/M. | Part II. Other significant conditions conf | ributing to death but not resulting | g in the underlying cause gi | iven in Part I. | 23b. Did to | bacco use con | tribute to the cause of death? |
| v requires the been signe should be defend by | | | | | 24a. Was ar perform | autopsy ned? | Probably 42 Unknown 24b. Were autopsy findings available prior to completion of cause of death? |
| | 25. Was case referred to medical examiner? | | | 26. Place of Dea | 1 ☑ Ye | s 2 No | 1.2Yes 2□ No |
| £ 63 | 1 TeyYes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | | b. Time of linjury 28c. Injury | | orne 5 Reside 28d. Describe ho | | |
| tal or Attanding P rs after death. al Director: After i led in by the funer. Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Ne Hospita n 24 hours ne Funeral pletaly fille edical C | | clan: To the best of my knowled er: On the basis of examination and manner stated. | | | | | |
| To the within To the comple | 29b. Signature and title of certifier | Much | 29c. Licen OCI | | | d. Date signed | (Month, Day, Year) |
| 4 | 30. Name and address of person who cor Stephen S. (2) 31. Date filed (Month, Day, Year) | | i) (Type, Print) 111 Penn Str | eet, Balt | imore, Ma | aryland | 21201 |

Registrar

APR 2 6 1999 Show B. Apoll

